

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12000 CERTIFICATE OF DEATH											
11996											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital						d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Lula Middle Elizabeth Last Adkins			4. DATE OF DEATH Month August Day 13 Year 19 66								
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 19/1886		9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired County School Teacher				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Mardela (Wicomico Co) Md.			12. CITIZEN OF WHAT COUNTRY? U S A		
13. FATHER'S NAME Edward Wright						14. MOTHER'S MAIDEN NAME Emma Holloway					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. 219-07-7032		17. INFORMANT Robert L. & Carroll W. Adkins (Sons) Salisbury Md. - Mardela, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) Hypertension DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 6 Weeks 15 Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/10/66 , 19 19 , to 8/13/66 , 19 19 , that (I) (we) last saw the deceased alive on 8/13/66 , 19 19 , and that death occurred at 8:50M , from the causes and on the date stated above.											
22a. SIGNATURE Charles H Winnacott						A.M. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-13-66			
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.						22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Aug. 16/1966		23c. NAME OF CEMETERY OR CREMATORY Mardela Mem. Cemetery (Old Sect.) Mardela, Md.			23d. LOCATION (City, town or county) (State) Mardela, Md.		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 16 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

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11986

Nov. 19, 1986

Retired County School Teacher

Edward W. King

219-07-7035

Robert L. A. Carroll (Sons)

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HOLWAY & COMPANY

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CERTIFICATE OF DEATH

11997

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>23-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SPRING HILL NURSING HOME</u>		d. STREET ADDRESS <u>S. MAIN ST</u>	
3. NAME OF DECEASED (Type or print) First <u>ROLAND</u> Middle <u>W.</u> Last <u>BEAUCHAMP</u>		4. DATE OF DEATH Month <u>AUG</u> Day <u>14</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30, 1902</u>
9. AGE (In years last birthday) <u>64</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POULTRY ENT.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>FEEDY POULTRY</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>BERLIN, WORE MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES S. BEAUCHAMP</u>		14. MOTHER'S MAIDEN NAME <u>SALLIE MARTHA HASTINGS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. R.W. BEAUCHAMP</u>		Address <u>BERLIN MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary + cerebral, arterio</u> DUE TO (c) <u>sclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>Months</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Parkinsonism - severe</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/10</u> , 19 <u>66</u> , to <u>5/10</u> , 19 <u>66</u> , that <u>we</u> last saw the deceased alive on <u>5/10</u> , 19 <u>66</u> , and that death occurred at <u>7:25 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>8-18-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Oswald J. Burton, M.D.</u>		22d. ADDRESS <u>MEDICAL CENTER, SALISBURY, MD.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8/16/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS CHURCHYARD</u>		23d. LOCATION (City or Town) (County) (State) <u>BERLIN WORE MD</u>	
24. FUNERAL DIRECTOR <u>Anna A. Burdage Berlin Md</u>		25a. REC'D BY REGISTRAR <u>AUG 22 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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FOR STATE
HEALTH DEPT.

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Division of STATISTICAL RESEARCH AND RECORDS, 301-W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11998

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN 1b 27 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 163 OCEAN CITY RD.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WICOMICO c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY d. STREET ADDRESS 163 OCEAN CITY RD. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) HELEN JONES BENSON		4. DATE OF DEATH AUGUST 23, 1966		5. SEX female		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH APR. 25, 1906		9. AGE (In years last birthday) 60 Yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME				11. BIRTHPLACE (State or foreign country) PENNSYLVANIA				12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME HARRY JONES				14. MOTHER'S MAIDEN NAME MAE E. CATLIN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO				16. SOCIAL SECURITY NO. 217-16-9524				17. INFORMANT J. LEE BENSON SEE 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Generalized Peritonitis Ruptured Gastric Ulcer 501 DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH 2 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Earl L. Royer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 8-25-66							
EXAMINER'S NAME (Type) EARL L. ROYER M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS SALISBURY, MARYLAND				22d. LOCATION (City, town, or country) (State) SALISBURY, MARYLAND							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				22b. DATE THEREOF 8/25/1966				22c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY				24a. REC'D BY REGISTRAR AUG 29 1966							
23. FUNERAL DIRECTOR George C. Hise				ADDRESS SALISBURY, MARYLAND				24b. REGISTRAR'S SIGNATURE Charles Judge											

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give names 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
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Item 2 from birth cert. MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
12003 CERTIFICATE OF DEATH 11999													
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u> ✓							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> 232							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>						d. STREET ADDRESS <u>3 Dorchester St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES BREWER BRASHER</u>			4. DATE OF DEATH Month Day Year <u>August 7 1966</u>			5. SEX <u>Male</u>			6. COLOR OR RACE <u>W</u>				
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>Aug. 4, 1966</u>			9. AGE (in years last birthday) yrs. Months Days Hours Min. <u>23</u>			10. IF UNDER 1 YEAR IF UNDER 24 HRS.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>SALISBURY MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LARRY BRASHER</u>						14. MOTHER'S MAIDEN NAME <u>KATE JONES</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>LARRY BRASHER</u>				Address <u>Ocean City MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hemorrhage (basilar)</u> 7605 DUE TO (b) <u>Perinatal Hypoxia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Prematurity (Birth wt 2345 gms)</u>												INTERVAL BETWEEN ONSET AND DEATH <u>76 hrs (approx)</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (1) (this hospital) attended the deceased from <u>8/4</u> , 19 <u>66</u> , to <u>8/7</u> , 19 <u>66</u> , that (1) (we) last saw the deceased alive on <u>8/6</u> , 19 <u>66</u> , and that death occurred at <u>3:30</u> AM, from the causes and on the date stated above.													
22a. SIGNATURE <u>Alfred C Kolls</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS <u>Medical Center Salisbury Maryland</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>8/9/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BUCKINGHAM</u>			23d. LOCATION (City, town or county) (State) <u>BERLIN MD</u>					
24. FUNERAL DIRECTOR <u>Anna A. Burloge</u>						ADDRESS <u>Berlin Md</u>			25a. REC'D BY REGISTRAR <u>AUG 10 1966</u>			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parsonsborg		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Parsonsborg	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.D. #1		d. STREET ADDRESS R.D.#1	
3. NAME OF DECEASED (Type or print) First Elsie Middle Martha Last Brittingham		4. DATE OF DEATH Month August Day 20 Year 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 25, 1906
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (County & State, or foreign country) Powellville, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Lewis		14. MOTHER'S MAIDEN NAME Edith Powell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) -		16. SOCIAL SECURITY NO. 213-42-2296	
17. INFORMANT Mrs. Mary Morris (daughter) Rt. 1, Parsonsborg, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) adenocarcinoma metastasized to intestines 1992 DUE TO (b) 1-2 yrs? Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from July , 19 65 , to 8-20 , 19 66 , that (I) (we) last saw the deceased alive on 8-18 , 19 66 , and that death occurred at 7P M, from the causes and on the date stated above.			
22a. SIGNATURE Frank Lewis		22b. DATE SIGNED 8/22/66	
22c. PHYSICIAN'S NAME (Type) Dr. Frank Lewis		22d. ADDRESS Willards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 23, 1966	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City, town or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 24 1966	
		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12005						12001					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <u>Wicomico</u> MARYLAND						a. STATE <u>MD</u> b. COUNTY <u>SOMERSET</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PRINCESS ANNE RT 1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>						d. STREET ADDRESS <u>19-2</u>					
3. NAME OF DECEASED (Type or print) <u>EDWARD D. BROWN</u>						4. DATE OF DEATH <u>August 23 1966</u>					
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2-18-1920</u>		9. AGE (In years last birthday) <u>46</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MASONRY</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Somerset MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN BROWN</u>						14. MOTHER'S MAIDEN NAME <u>HELEN LEATHERBURY</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>				16. SOCIAL SECURITY NO. <u>218-14423</u>		17. INFORMANT <u>BELLA BROWN-PRINCESS</u>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										INTERVAL BETWEEN ONSET AND DEATH <u>few hours</u>	
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u>											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4201</u> DUE TO											
(c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/23</u> , 19 <u>66</u> , to <u>8/23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> , 19 <u>66</u> , and that death occurred at <u>4:45</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>[Signature]</u>						22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>8/27/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Epiph Rd Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Princess Anne Somerset Md</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u>						ADDRESS <u>Salisbury</u>		25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	
						DATE <u>AUG 29 1966</u>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12006					12002				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital D.O.A.</u>					2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>225 Maryland Avenue</u> d. STREET ADDRESS <u>Salisbury, Maryland</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>JOHN</u> Middle <u>ALBERT</u> Last <u>BROWN</u>			4. DATE OF DEATH Month <u>August</u> Day <u>12</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1884</u>		9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>2</u> Days <u>24</u> Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County, Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Brown</u>					14. MOTHER'S MAIDEN NAME <u>Virginia Parker</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>219-46-4394-T</u>		17. INFORMANT <u>Mrs. Lucy J. Brown (Wife)</u> <u>225 Maryland Ave., Salisbury, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis (heart disease)</u> 4200 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>3-7</u> , 19 <u>64</u> , to <u>8-13</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-13</u> , 19 <u>66</u> , and that death occurred at <u>8:11</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Wilbur R. Ellis</u>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>Aug. 13, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Wilbur R. Ellis</u>					22d. ADDRESS <u>Salisbury, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>August 15, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>AUG 16 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12007 CERTIFICATE OF DEATH 12003									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>					c. LENGTH OF STAY IN 1b <u>22-1</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>					d. STREET ADDRESS <u>605 Hill St.</u>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARtha</u> <u>GAINES</u> <u>BROWN</u>					4. DATE OF DEATH Month Day Year <u>August 21</u> <u>1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-10-1894</u>		9. AGE (in years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JAMES GAINES</u>					14. MOTHER'S MAIDEN NAME <u>EASTER GAINES</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>HOSPITAL REC. SALISBURY, MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pyelonephritis 2° Nephroses</u> (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Cerebral arteriosclerosis</u>									INTERVAL BETWEEN ONSET AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-14</u> , 19 <u>66</u> , to <u>8-21</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-20</u> - 19 <u>66</u> , and that death occurred at <u>5:40</u> A.M. from the causes and on the date stated above.									
22a. SIGNATURE <u>James B. Pashieff</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/21/66</u>
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>8-25-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>MT ZION CEM.</u>		23d. LOCATION (City, town or county) (State) <u>Wicomico, MD</u>		
24. FUNERAL DIRECTOR <u>JAMES B. PASHIEFF</u>					ADDRESS <u>Easton, MD</u>		25a. REC'D BY REGISTRAR <u>AUG 24 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12008					12004				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>305 Cedar Drive</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Hance</u> Middle <u>Junior</u> Last <u>Caldertv</u>			4. DATE OF DEATH Month <u>August</u> Day <u>2</u> Year <u>1966</u>						
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>August 2, 1966</u>		9. AGE (in years last birthday) yrs. <u>0</u> Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>N/A</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Hance Junior Calder</u>					14. MOTHER'S MAIDEN NAME <u>Rose Mary Dryden</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mr. Hance J. Calder, 305 Cedar Drive Salisbury, Maryland</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia prematurity</u> <u>7615</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Aborted Placenta</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at <u>8:45</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Gladys M. Allen</u>					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Aug 2, 1966</u>		
22c. PHYSICIAN'S NAME (Type) <u>Dr. Gladys M. Allen</u>					22d. ADDRESS <u>224 N. Division St. Salisbury, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Aug. 4, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>		
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>AUG 4 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

12004

CERTIFICATE OF DEATH

12004

Wisconsin

Married

Salisbury

305 Cedar Drive

Junior

Rank

Salisbury, Maryland

XA

Mr. Robert J. Collier, 305 Cedar Drive

Salisbury, Maryland

No

N/A

Dr. George N. Allen

304 W. Division St., Salisbury, Md.

Salisbury, Md., 1968 Wisconsin Memorial Park Salisbury, Maryland

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COMPANY SALISBURY

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item #7 Film #G380 8/24/66 pc

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS 107 Pine St.	
3. NAME OF DECEASED (Type or print) Lillie M Calhoun		4. DATE OF DEATH Month 8 Day 15 Year 66	
5. SEX F	6. COLOR OR RACE W	7. MARRIED WIDOWED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-25-1886
9. AGE (In years birth day) yrs. 79		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Delmar, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel J. Adams		14. MOTHER'S MAIDEN NAME Amelia Elliott	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Mary McClaine, Delmar, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5721 IMMEDIATE CAUSE (a) Peritonitis DUE TO (b) Ruptured diverticulum of colon DUE TO (c) hours		INTERVAL BETWEEN ONSET OF ILLNESS AND DEATH hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 8-17-66	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		Address (Street, city, town, or county) 409 Camden Ave. Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-18-66	
23c. NAME OF CEMETERY OR CREMATORY St Stephens		23d. LOCATION (City or Town) (County) (State) Delmar, Del.	
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.		25. REGISTRY BY REGISTRAR AUG 19 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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[Handwritten signature]

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12010

CERTIFICATE OF DEATH

12006

1. PLACE OF DEATH a. COUNTY <p style="text-align: center;">Wicomico</p>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <p style="text-align: center;">Maryland</p> b. COUNTY <p style="text-align: center;">Queen Anne's</p>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <p style="text-align: center;">Salisbury</p>		c. LENGTH OF STAY IN 1b <p style="text-align: center;">7 Days</p>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <p style="text-align: center;">Deer's Head State Hospital, Salisbury, Md.</p>		d. STREET ADDRESS <p style="text-align: center;">Grasonville</p>	
3. NAME OF DECEASED (Type or print) <p style="text-align: center;">Welford G. Carter</p>		4. DATE OF DEATH <p style="text-align: center;">8 15 19 66</p>	
5. SEX <p style="text-align: center;">Male</p>	6. COLOR OR RACE <p style="text-align: center;">Negro</p>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED	8. DATE OF BIRTH <p style="text-align: center;">10/10/1897</p>
9. AGE (In years last birthday) <p style="text-align: center;">68 yrs.</p>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <p style="text-align: center;">SELF EMPLOYED</p>		10b. KIND OF BUSINESS OR INDUSTRY <p style="text-align: center;">HAULING</p>	
11. BIRTHPLACE (County & State, or foreign country) <p style="text-align: center;">VIRGINIA</p>		12. CITIZEN OF WHAT COUNTRY? <p style="text-align: center;">U.S.A</p>	
13. FATHER'S NAME <p style="text-align: center;">RICHARD Smoot</p>		14. MOTHER'S MAIDEN NAME <p style="text-align: center;">CATHERINE CARTER</p>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <p style="text-align: center;">NO</p>		16. SOCIAL SECURITY NO. <p style="text-align: center;">218-14-4442</p>	
17. INFORMANT <p style="text-align: center;">WELFORD CARTER</p>		Address <p style="text-align: center;">Chester Town, Md</p>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <p style="text-align: center;">Peritoneal Abscess.</p> DUE TO (b) <p style="text-align: center;">Postoperative Cholecystectomy</p> DUE TO (c) <p style="text-align: center;">Chronic Cholecystitis - Necrotic</p>				INTERVAL BETWEEN ONSET AND DEATH <p style="text-align: center;">2 wks.</p>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <p style="text-align: center;">Obstruction</p>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <p style="text-align: center;">8/8</p> , 19 <p style="text-align: center;">66</p> to <p style="text-align: center;">8/15</p> , 1966, that (I) (we) last saw the deceased alive on <p style="text-align: center;">8/15</p> , 19 <p style="text-align: center;">66</p> , and that death occurred at <p style="text-align: center;">7:00 P.M.</p> from causes and on the date stated above.					
22a. SIGNATURE <p style="text-align: center;">C. H. Winnacott</p>				22b. DATE SIGNED <p style="text-align: center;">8/16/66</p>	
22c. PHYSICIAN'S NAME (Type) <p style="text-align: center;">C. H. Winnacott, M. D.</p>				22d. ADDRESS <p style="text-align: center;">Deer's Head State Hospital, Salisbury, Md.</p>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <p style="text-align: center;">BURIAL</p>		23b. DATE THEREOF <p style="text-align: center;">8/20/1966</p>		23c. NAME OF CEMETERY OR CREMATORY <p style="text-align: center;">JOSHUA CEMETERY</p>	
23d. LOCATION (City or Town) <p style="text-align: center;">R.F.D. Chester Town, Md</p>		(County)		(State)	
24. FUNERAL DIRECTOR <p style="text-align: center;">Remelt Valley</p>		ADDRESS <p style="text-align: center;">Chester Town, Md</p>		25. REC'D BY REGISTRAR DATE <p style="text-align: center;">AUG 18 1966</p>	
26. REGISTRAR'S SIGNATURE <p style="text-align: center;">Charles Judge</p>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15000

18010

10/10/81

X

WILSON CENTER
CHICKEN
U.S. GIN
10/10/81

218-1445
RICHARD
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

12011

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12007

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Delaware</i> b. COUNTY <i>Sussex</i> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Laurel</i> <i>HL-3</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>		d. STREET ADDRESS <i>R2 Whitesville Road</i>	
3. NAME OF DECEASED (Type or print) First <i>Charles</i> Middle <i>L.</i> Last <i>Casson</i>		4. DATE OF DEATH Month <i>August</i> Day <i>16</i> Year <i>1966</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 3, 1901</i>
9. AGE (In years last birthday) <i>65</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>own farm</i>	
11. BIRTHPLACE (County & State, or foreign country) <i>Tennessee</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>John C. Casson</i>		14. MOTHER'S MAIDEN NAME <i>Isabel Jones</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>195 X05 8791</i>	
17. INFORMANT <i>Mrs. Laura B. Casson</i>		Address <i>r2 Laurel, Del.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory insufficiency</i> <i>163X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Carcinoma of lung with metastases</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>8/15</i> , 19 <i>66</i> , to <i>8/16</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/16</i> , 19 <i>66</i> , and that death occurred at <i>5:30</i> AM, from the causes and on the date stated above.			
22a. SIGNATURE <i>Richard E. Hughes</i>		22b. DATE SIGNED <i>8/19/66</i>	
22c. PHYSICIAN'S NAME (Type) <i>Richard E. Hughes</i>		22d. ADDRESS <i>Laurel, Del.</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>8/19/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>St. Stephens Cem</i>		23d. LOCATION (City, town or county) (State) <i>Delmar, Delaware</i>	
24. FUNERAL DIRECTOR <i>Charles Judge</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>AUG 23 1966</i>	

18007

18007

Super

Delaware

Delaware

Delaware

Delaware

USA

Tennessee

OWNERS

Delaware

Delaware

John O. Cannon

100-100-100

no

Delaware

St. Stephens

1910

1910

Delaware

Delaware

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME
6M 1/66

12012

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12008

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville		c. LENGTH OF STAY IN 1b 72-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Richardson Camp		d. STREET ADDRESS Richardson Camp	
3. NAME OF DECEASED (Type or print) First BETTY Middle CHASE Last CHASE		4. DATE OF DEATH Month 8-25-66 Day 19 Year 19	
5. SEX F	6. COLOR OR RACE AA	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-15-1927
9. AGE (In years last birthday) 39 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min. 11	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tomato peeler		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Laurel Del.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Duke Robinson - Pittsville Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Septicemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cellulitis, left breast DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 48 hours 11 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Scratched left breast on door at home.	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 8-14-66		20d. INJURY OCCURRED <input type="checkbox"/> While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home		20f. (City or town) (County) (State) Pittsville, Wicomico, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED August 26, 1966	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-28-66	23c. NAME OF CEMETERY OR CREMATORY Evergreen	23d. LOCATION (City or town) (County) (State) Berlin Wic. Md.
24. FUNERAL DIRECTOR Donation Jolley, Salisbury, Md.		25a. REC'D BY REGISTRAR DATE SEP 6 1966	
		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

15001

15001

ll-ll

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <div> <p>12013</p> <p>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</p> <p>CERTIFICATE OF DEATH</p> </div> <div> <p>12009</p> </div> </div>											
1. PLACE OF DEATH, COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL Hospital						d. STREET ADDRESS OAK LANE				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) T. J. CLEVELAND						4. DATE OF DEATH August 18 1966					
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-9-13		9. AGE (In years last birthday) 53 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) MARYLAND				12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME L. M. CLEVELAND						14. MOTHER'S MAIDEN NAME FANNY CLEVELAND					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)				16. SOCIAL SECURITY NO. 259-16-2885		17. INFORMANT JOETTER CLEVELAND Address BERLIN, MD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from chronic gastric ulcer 5400 DUE TO ulcer Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH 12 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Left sided Paralysis -											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Aug 6 PM , 19 66 to Aug 18 , 19 66 , that (I) (we) last saw the deceased alive on Aug 18 1966 , and that death occurred at 4 PM , from the causes and on the date stated above.											
22a. SIGNATURE Robert T. Adkins						M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 20 Aug 66			
22c. PHYSICIAN'S NAME (Type) ROBERT T. ADKINS						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City, town or county) (State)			
BURIAL		8-21-66		ANTIOCH CEMETERY				FRANKFORD - DELA.			
24. FUNERAL DIRECTOR Cl. Douglas Nelson, Frankford, Del.						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
						AUG 26 1966		Charles Judge			

1800

1801

W. J. Rice

2-12-01

Peninsula General Hospital

Chapel Hill

Dear Sir

I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the above named hospital.

I am sorry to hear that you are unable to visit the hospital at this time.

I am, however, glad to hear that you are still interested in the hospital.

I am, Sir, very respectfully,
Yours truly,
W. J. Rice

W. J. Rice, M.D.,
Peninsula General Hospital,
Chapel Hill, N.C.

Very truly,
W. J. Rice

Robert T. Atkins

August 10, 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR #15 (4)
2DM 1/65

<div style="display: flex; justify-content: space-between;"> <div> <p>12014</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH</p> </div> <div> <p>12010</p> </div> </div>									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Princess Anne			d. STREET ADDRESS 	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last Enoch ELIJAH Collins					4. DATE OF DEATH Month Day Year August 31 1966				
5. SEX MALE		6. COLOR OR RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/16/1900		9. AGE (In years last birthday) 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U S A.		
13. FATHER'S NAME Irvin Collins					14. MOTHER'S MAIDEN NAME Gertrude ?				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT Address Frank Collins. Middletown, Delaware				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MASSIVE HEMORRHAGE 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ESOPHAGEAL CARCINOMA DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DIABETES MELLITUS DIAPHRAGMATIC HERNIA									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>30 August, 1966</u> to <u>31 Aug.</u>, 19<u>66</u> that (I) (we) last saw the deceased alive on <u>31 Aug.</u> 19<u>66</u>, and that death occurred at <u>9:45</u> M., from the causes and on the date stated above.									
22a. SIGNATURE D.M. Bouieky					22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)		
22d. ADDRESS					22e. M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 6/3/65		23c. NAME OF CEMETERY OR CREMATORY Mt Hope AMeZ		23d. LOCATION (City, town or county) (State) Princess Anne, Md		
24. FUNERAL DIRECTOR William H. James Jr. Princess Anne, Md					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE Charles Judge		
DATE SEP 7 1966									

1804

1804

Wisconsin

California

Peninsula General Hospital

1804

U. S. A.

Wisconsin

California

Peninsula General Hospital

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Peninsula General Hospital

U. S. A.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12015 CERTIFICATE OF DEATH 12011											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> <u>22-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>80 Peninsula General Hospital</u>						d. STREET ADDRESS <u>417 PENNA. AVE</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Houston</u> Middle <u>Quinn</u> Last <u>Coulter</u>			4. DATE OF DEATH Month <u>August</u> Day <u>3</u> Year <u>1966</u>								
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 12, 1912</u>		9. AGE (If years last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>GRADER OPER. CONSTRUCTION</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>INDIANA</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		
13. FATHER'S NAME <u>JEFFERY COULTER</u>						14. MOTHER'S MAIDEN NAME <u>COCA QUINN</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES</u> <u>1938-1941</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. MARY M. COULTER</u>		Address <u>417 PENNA AVE SALISBURY MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bleeding esophageal varicose</u> <u>5810</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Decompensated hepatic cirrhosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>7-12</u> , 19 <u>66</u> , to <u>8-3</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-3</u> 19 <u>66</u> , and that death occurred at <u>8 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>James R. Cofford</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/3/66</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas F. Wallace</u>						22d. ADDRESS <u>Medical Center Salisbury MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>8-5-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEM.</u>		23d. LOCATION (City, town or county) (State) <u>SALISBURY MD.</u>					
24. FUNERAL DIRECTOR <u>Thomas F. Wallace</u>						ADDRESS <u>SALISBURY MD.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 5 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

LOST

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12016 Item #9 Rm #0300 8/23/66 80											
12012											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>						d. STREET ADDRESS <u>R.F.D. #2</u>					
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>H</u> Last <u>DAVIS</u>						4. DATE OF DEATH Month <u>August</u> Day <u>16</u> Year <u>1966</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov 16 1889</u>		9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>North Carolina</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>A. Calvin Hattenstein</u>						14. MOTHER'S MAIDEN NAME <u>Ada Rhodes</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>216 40 3558</u>		17. INFORMANT <u>Mrs. Madge Westhall, Snow Hill, Md</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic CA rectum</u> 154X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>6/27, 1966</u> to <u>8/16, 1966</u> , that (I) (we) last saw the deceased alive on <u>8/16, 1966</u> , and that death occurred at <u>2:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>W. P. Sadler</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>W. P. SADLER MD.</u>						22d. ADDRESS <u>MEDICAL CENTER SALISBURY MD.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY- <u>Bates Methodist</u>				23d. LOCATION (City, town or county) (State) <u>Snow Hill Maryland</u>			
24. FUNERAL DIRECTOR <u>Thomas T. Harris, Snow Hill, Md.</u>						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
						DATE <u>AUG 22 1966</u>					

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[Faint, mostly illegible handwritten text and markings across the page, including what appears to be a signature and various notations.]

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12017

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12013

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Record St.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Margaret M. DAVIS</u>		4. DATE OF DEATH Month Day Year <u>AUGUST 21 1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 26 1904</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing room</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Pittsville Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Artie W Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Ellis M. Nichols</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218 01 6304</u>	
17. INFORMANT <u>Wm. A. Davis</u>		Address <u>640 South Ave. Secane, Pa.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4341</u> DUE TO <u>Congestive Heart Failure</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Failure</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <u>2 mo</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8-21, 1966</u> to <u>8-21, 1966</u> that (I/we) last saw the deceased alive on <u>8-21, 1966</u> , and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>William B. Smith</u>		22b. DATE SIGNED <u>8-21-66</u>	
22c. PHYSICIAN'S NAME (Type) <u>William B. Smith</u>		22d. ADDRESS <u>Attending Phys. M.D.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-24-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Dale Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Whaleyville Maryland</u>
24. FUNERAL DIRECTOR <u>Norman F. Morris, Snow Hill, Md.</u>		25a. REC'D BY REGISTRAR <u>AUG 24 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

E10Si1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12013					12014				
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Del b. COUNTY Sussex c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) millsboro d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) ROBERT			First Middle Last		4. DATE OF DEATH DAVIS		Month Day Year AUGUST 30 1966		
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/18/21		9. AGE (In years last birthday) 45 yrs. 5 Months 9 Days 9 Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Nelsonville Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John Davis					14. MOTHER'S MAIDEN NAME Virginia Justice				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. 222-05-3885		17. INFORMANT Angela Davis Address Delbyville Del			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lymphosarcoma 2001 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								INTERVAL BETWEEN ONSET AND DEATH 18 mos	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 13, 1966 , to Aug 30, 1966 , that (I) (we) last saw the deceased alive on Aug 30, 1966 , and that death occurred at 3 P. M, from the causes and on the date stated above.									
22a. SIGNATURE Thomas C. Hill Jr.						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED August 30, 1966	
22c. PHYSICIAN'S NAME (Type) Thomas C. Hill Jr.						22d. ADDRESS Pine Bluff Road, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/3/66		23c. NAME OF CEMETERY OR CREMATORY A.M.E.		23d. LOCATION (City, town or county) (State) Northtown Del		25a. REC'D BY REGISTRAR SEP 2 1966	
24. FUNERAL DIRECTOR William Berzoff, Milford, Del						25b. REGISTRAR'S SIGNATURE Charles Judge			

15011

CERTIFICATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

12019

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12015

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Route 1		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) Carrie		4. DATE OF DEATH Month 8 Day 1 Year 66	
5. SEX F	6. COLOR OR RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1898
9. AGE (In years lost in day) yrs. 68		10. IF UNDER 1 YEAR Months 19 Days 19 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unk		14. MOTHER'S MAIDEN NAME unk	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. unk	
17. INFORMANT James Deshields		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH Sudden
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22. DATE SIGNED 8-1-66		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Buried		23b. DATE THEREOF Aug 5-66	
23c. NAME OF CEMETERY OR CREMATORY Lyons Cem		23d. LOCATION (City or Town) (County) (State) Lyons MD	
24. FUNERAL DIRECTOR Borber MD Wash		25a. REC'D BY REGISTRAR DATE AUG 8 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items #7,8 & 9 Film #G380 8/26/66 pc

CERTIFICATE OF DEATH

12020

12016

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 218 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		d. STREET ADDRESS RFD #3	
3. NAME OF DECEASED (Type or print) Thomas Henry Fitzgerald		4. DATE OF DEATH Month 8 Day 17 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 16, 1887
9. AGE (In years lost birthday) yrs. 79		10. IF UNDER 1 YEAR Months 17 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) MONIE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME THOMAS HENRY FITZGERALD		14. MOTHER'S MAIDEN NAME GEORGIA WALLER	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT MRS. ANNA LOIS LEWICK		Address DAMASCUS, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO BRONCHIOGENIC Carcinoma lung metastases DUE TO with extensive mediastinal metastases DUE TO		INTERVAL BETWEEN ONSET AND DEATH 3 weeks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) Arteriosclerosis - Gen; Osteoarthritis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1/11 , 19 66 , to 8/17 , 19 66 , that (I) (we) last saw the deceased alive on 8/17 , 19 66 , and that death occurred 06:05 P.M. from causes and on the date stated above.			
22a. SIGNATURE C. H. Winnacott		22b. DATE SIGNED 8/18/66	
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/21/1966	
23c. NAME OF CEMETERY OR CREMATORY ST. ANDREW CEMETERY		23d. LOCATION (City or Town) (County) (State) PRINCESS ANNE, MD.	
24. FUNERAL DIRECTOR LEVIN R. WILSON		25a. REC'D BY REGISTRAR DATE AUG 23 1966	
ADDRESS HOME		25b. REGISTRAR'S SIGNATURE Charles Judge	

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U.S.A.

ROUTE, SAN LAND

ROUTE, SAN LAND

GEORGIA WALTER

THOMAS HENRY FITZGERALD

MRS. ANNA LOUISE LAYTON LAYTONS, JR.

PRINCESS ANNE, JR.

ST. ANNE'S CATHEDRAL

8/21/1966

ROUTE

LEVIN L. WILSON WILSON L. WILSON

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12021					12017				
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			d. STREET ADDRESS <i>224 Newton Street</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <i>Elaine</i>		Middle <i>Elizabeth</i>		Last <i>Foust</i>		4. DATE OF DEATH Month <i>August</i>		Day Year <i>9 1966</i>	
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>January 10, 1888</i>		9. AGE (In years last birthday) <i>78</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. <i>6 29</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) <i>Deal Island, Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Eldridge Windsor</i>					14. MOTHER'S MAIDEN NAME <i>Mary Webster</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>			16. SOCIAL SECURITY NO. <i>497-14-7471-B</i>		17. INFORMANT Address <i>Edward Eugene Foust (Husband) 224 Newton St., Salisbury, Maryland</i>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> 4281 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>generalized atherosclerosis</i>								INTERVAL BETWEEN ONSET AND DEATH <i>12 hr.</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>7/15</i> , 19 <i>66</i> , to <i>8/9</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/9</i> , 19 <i>66</i> , and that death occurred at <i>7A</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Earl Beardsley</i>					22b. DATE SIGNED			22c. PHYSICIAN'S NAME (Type) <i>EARL BEARDSLEY</i>	
22d. ADDRESS <i>MARYLAND AVE. Salisbury, Md.</i>					22e. REC'D BY REGISTRAR DATE <i>AUG 11 1966</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b. DATE THEREOF <i>August 11, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>		
24. FUNERAL DIRECTOR ADDRESS <i>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</i>					25a. REC'D BY REGISTRAR DATE <i>AUG 11 1966</i>				
					25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



Source: *Author's calculations*.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 5-63

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12022				Item #9 Film #G350 9/19/66 pc				13401			
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)			d. STREET ADDRESS		
Wicomico			Quantico			Maryland			Quantico		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						e. IS RESIDENCE ON A FARM?					
Rt 1, Quantico, Maryland						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First Middle Last						Month Day Year					
Levin T. Gale						August 26 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) / 9391 yrs.		IF UNDER 1 YEAR	
Male		C				8/1/1875				Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
Merchant				Store				Maryland			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
Unknown						Mary Gale					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)						16. SOCIAL SECURITY NO.					
No											
17. INFORMANT						Address					
Hopson Gale						Quantico, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a)											
4222 DUE TO Degenerative Heart Disease											
Conditions, if any, which gave rise to immediate cause (b)											
(e), stating the underlying cause last. DUE TO											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 1966 to 26 Aug 66 that (I) (we) last saw the deceased alive on 1966, and that death occurred at 1966 from the causes and on the date stated above.											
22a. SIGNATURE F. A. Purnell M.D. 22b. DATE 7 Sept 66											
22c. PHYSICIAN'S NAME (Type) F. A. Purnell 22d. ADDRESS Salisbury, N.J.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 9/3/66 23c. NAME OF CEMETERY OR CREMATORY Quantico cemetery 23d. LOCATION (City, town or county) (State) Quantico, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS 25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE											
Charles E. Stewart Salisbury, Md. DATE SEP 13 1966 f Charles Judge											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12023					12018				
Item 7-1111-6300 4/6/66 mh									
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>WICOMICO</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DELMAR</i>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Peninsula General Hospital</i>					d. STREET ADDRESS <i>208 CHESTNUT</i>				
3. NAME OF DECEASED (Type or print) First <i>Hubert</i> Middle <i>Warren</i> Last <i>German</i>					4. DATE OF DEATH Month <i>August</i> Day <i>27</i> Year <i>1966</i>				
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>10-7-1892</i>		9. AGE (In years last birthday) <i>73</i> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>JEWELER</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>JEWELRY</i>			11. BIRTHPLACE (County & State, or foreign country) <i>DELAWARE</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>HARVEY GERMAN</i>					14. MOTHER'S MAIDEN NAME <i>JENNIE BENSON</i>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>YES</i>			16. SOCIAL SECURITY NO. <i>220-32-0064</i>		17. INFORMANT <i>ELIZABETH GERMAN</i>			Address <i>DELMAR-MD</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chemia</i> 230x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <i>Tumor left kidney</i> (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Atherosclerosis, Anteriorly occluded Heart Arteries</i>								INTERVAL BETWEEN ONSET AND DEATH <i>3 months</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>8/26</i> , 19 <i>66</i> , to <i>8/28</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/28</i> , 19 <i>66</i> and that death occurred at <i>5:20</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Hubert Warren German</i>					22b. DATE SIGNED				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>			23b. DATE THEREOF <i>8-30-66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>PARSONS</i>		23d. LOCATION (City, town or county) (State) <i>SALISBURY-MD</i>		
24. FUNERAL DIRECTOR <i>Charles W. Marul - Delmar, Del.</i>					25a. REC'D BY REGISTRAR <i>AUG 30 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

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ORCHESTRA

HARVEY GARNAN TENNIS TENNIS TENNIS

WV 200-20-04 ELIZABETH GARNAN

WV 200-20-04 ELIZABETH GARNAN

WV 200-20-04 ELIZABETH GARNAN

WV 200-20-04 ELIZABETH GARNAN

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12024

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12019

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN lb			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital				d. STREET ADDRESS 19 St. Louis Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last TINNA B. HADDER				4. DATE OF DEATH Month Day Year 8-18-66 19			
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8-19-1880 83 yrs.	
9. AGE (In years last birthday) 85 yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS Hours Min.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) BERLIN MD	
13. FATHER'S NAME ASHER FISHER				14. MOTHER'S MAIDEN NAME LAURA GRAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No				16. SOCIAL SECURITY NO. No		17. INFORMANT Address Mrs. EDNA JARVIS OCEAN CITY MD	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO 9040 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Aspiration of Vomitus DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Fractured neck of left femur.							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH Minutes			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) Fell at home.			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 7-3-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home		20f. (City or town) (County) (State) Ocean City, Worcester, Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , <u>Inspection</u> <input checked="" type="checkbox"/> , <u>Inquiry</u> <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , <u>Accident</u> <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				22. DATE SIGNED August 22, 1966			
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/22/66		23c. NAME OF CEMETERY OR CREMATORY SUNSET MEMORIAL PARK		23d. LOCATION (City or Town) (County) (State) BERLIN WIDE MD.	
24. FUNERAL DIRECTOR Burbage Funeral Home, Berlin, Md.				25a. REC'D BY REGISTRAR DATE AUG 24 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

15010

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[Handwritten signature]

2381 304

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12025 CERTIFICATE OF DEATH 12022

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 104 W. Isabella Street		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 104 W. Isabella Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First AGNES Middle MARIE Last HENTSCHEL		4. DATE OF DEATH Month August Day 24 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 19, 1890
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired - Saleslady		10b. KIND OF BUSINESS OR INDUSTRY Dept. Store	9. AGE (In years last birthday) 75 yrs. IF UNDER 1 YEAR Months 11 Days 5 IF UNDER 24 HRS. Hours 5 Min.
11. BIRTHPLACE (County & State, or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Paul Hentschel		14. MOTHER'S MAIDEN NAME (unk.)	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-09-5885	
17. INFORMANT Mr. Clay L. Hentschel (Son) Address 104 W. Isabella St., Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease DUE TO (b) Coronary Artery Sclerosis DUE TO (c) Diabetes Mellitus; Osteoarthritis PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus; Osteoarthritis 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1960 , to Aug 24, 1966 , that (I) (we) last saw the deceased alive on Aug 22 1966 , and that death occurred at 9 A.M. from the causes and on the date stated above.			
22a. SIGNATURE David J. Gilmore		22b. DATE SIGNED Aug. 25, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 27, 1966	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 29 1966 DATE 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12026 CERTIFICATE OF DEATH 12023

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MILLSBORO</u> d. STREET ADDRESS <u>46-3</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>MARVEL</u> 4. DATE OF DEATH Month Day Year <u>AUGUST 22 1966</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>MARCH 19, 1895</u> 9. AGE (in years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. <u>5 3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED COUNTRYMAN</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u> 11. BIRTHPLACE (County & State, or foreign country) <u>DELAWARE</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>THEODORE M. HOPKINS</u> 14. MOTHER'S MAIDEN NAME <u>ANNIE L. FOWLER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>UNKNOWN</u> 16. SOCIAL SECURITY NO. <u>222-07-1881</u> 17. INFORMANT <u>JENNIE HOPKINS - MILLSBORO, DEL.</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332X DUE TO (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-9-1966</u> , to <u>8-22-1966</u> , that (I) (we) last saw the deceased alive on <u>8-21-1966</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Jimmie C. Cypel</u> 22c. PHYSICIAN'S NAME (Type) <u>Medical Center Salisbury</u>		22b. DATE SIGNED <u>AUG 26 1966</u> 22d. ADDRESS <u>Medical Center Salisbury</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>8-25-66</u> 23c. NAME OF CEMETERY OR CREMATORY <u>ST. GEORGES CEMETERY</u> 23d. LOCATION (City, town or county) (State) <u>CLARKSVILLE, DELA</u>		24. FUNERAL DIRECTOR <u>U. Douglas Nelson, Frankford, Delaware</u> 25a. REC'D BY REGISTRAR <u>Charles Judge</u> 25b. REGISTRAR'S SIGNATURE <u>DATE AUG 26 1966</u>	

15053

STATE DEPARTMENT OF HEALTH
CLERK'S OFFICE

15053

NOTICE OF
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[Faint, illegible text, likely bleed-through from the reverse side of the page]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12027 CERTIFICATE OF DEATH 12024

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				e. STREET ADDRESS <u>Bishopville</u>			
3. NAME OF DECEASED (Type or print) First <u>Blanche</u> Middle <u>M.</u> Last <u>Hudson</u>				4. DATE OF DEATH Month <u>August</u> Day <u>24</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-1-1897</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Lavenia Vinson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>579-40-5984</u>		17. INFORMANT Address <u>Mr. William Hudson, Bishopville, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cocaine</u> DUE TO (b) <u>Carcinoma</u> DUE TO (c) <u>Carcinoma of ovary</u> CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8/19</u> , 19 <u>66</u> , to <u>8/24</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/24</u> , 19 <u>66</u> and that death occurred at <u>11:30</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Richard E. Hughes</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-29-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>	
24. FUNERAL DIRECTOR <u>A. Douglas Melson</u> ADDRESS <u>Frankford, Dela.</u>				25a. REC'D BY REGISTRAR <u>SEP 6 1966</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12028

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12025

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Montana</u> b. COUNTY <u>Livingston</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Livingston</u> 63-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ERNEST</u> Middle <u>J.</u> Last <u>Hudson</u>		4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-24-41</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Force</u>	9. AGE (In years last birthday) yrs. <u>25</u>
11. BIRTHPLACE (State or foreign country) <u>Calif.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>BYRON E. Hudson</u>		14. MOTHER'S MAIDEN NAME <u>Hennie Christiansen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>516-46-5195</u>	17. INFORMANT <u>Air Force</u> Address <u>Dover, Del.</u>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound Fracture skull</u> DUE TO (b) <u>8254</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>DUE TO</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Multiple fractures arms, legs, chest</u>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Single car accident.</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>12:50 p.m.</u> <u>8-13</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 13</u>
20f. (City or town) <u>Salisbury</u> (County) <u>Del.</u> (State)		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <u>Philip A. Insley</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Phil. A. Insley</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		Address (Street, city, town, or county)	
22. DATE SIGNED <u>8-13-66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-18-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mountain View</u>		23d. LOCATION (City or town) (County) (State) <u>Livingston Mon.</u>	
24. FUNERAL DIRECTOR <u>William J. Eschmeyer</u>		25a. REC'D BY REGISTRAR <u>SEP 1 1966</u>	
ADDRESS <u>Georgetown W.D.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

MEDICAL CERTIFICATION

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12029

12026

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Tyaskin		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Tyaskin	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Lelia Middle Hughes Last Hughes		4. DATE OF DEATH Month 8 Day 1 Year 19 66	
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/1/87
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months 22 Days 1	11. IF UNDER 24 HRS. Hours 1 Min. 66
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Wicomico, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Gaines		14. MOTHER'S MAIDEN NAME Lizzie Hughes	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. -	
17. INFORMANT Mrs Lessie Cross, Salisbury, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Coronary thrombosis Conditions, if any, which gave rise to immediate cause (b) Arteriosclerosis heart disease (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 16 July 19 66 to 1 Aug 19 66 , that (I) (we) last saw the deceased alive on July 23 19 66 , and that death occurred at 9:15 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Robert J. Adams M.D.		22b. DATE SIGNED 5 Aug 66	
22c. PHYSICIAN'S NAME (Type) Robert J. Adams		22d. ADDRESS FRUITLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/7/66	23c. NAME OF CEMETERY OR CREMATORY New Town Cemetery	23d. LOCATION (City, town or county) (State) Tyaskin, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE C. J. Messing		25a. REC'D BY REGISTRAR AUG 9 1966	
ADDRESS Bivalve, Maryland		25b. REGISTRAR'S SIGNATURE James J. Jones	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12030

12027

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mardela-Sharptown Rd</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Vienna</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS <u>—</u>	
3. NAME OF DECEASED (Type or print) First <u>Norman</u> Middle <u>Dail</u> Last <u>Hurley</u>		4. DATE OF DEATH Month <u>August</u> Day <u>13th</u> Year <u>19 66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/27/28</u>
9. AGE (In years, months, days) <u>37</u> yrs. <u>3</u> months <u>—</u> days		10. IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer - La Pont Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Walter J. Hurley</u>		14. MOTHER'S MAIDEN NAME <u>Alberta Langfitt</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Russell Hurley, Vienna, Md.</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto run off - aphyxiation</u> 8234 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car overturned--</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>8-13-66</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Mardela-Sharptown Rd.</u>		20f. (City or town) <u>car.</u> (County) <u>Wic.</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Phillip A. Insley Sr.</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Phillip A. Insley Sr.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>8/15/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Dor. Memorial</u>		22d. LOCATION (City, town, or country) (State) <u>Cambridge Md</u>	
23. FUNERAL DIRECTOR <u>Ruth S. Mulroughy, East New Market, Md.</u>		24a. REC'D BY REGISTRAR <u>Aug 16 1966</u>	
		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

6-212596

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12031 Items 3,5,14 Film 9580 9/14/66 mb 12029											
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND						2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Md. b. COUNTY Wicomico					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 22.1					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						d. STREET ADDRESS					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last Kelley KELLY						4. DATE OF DEATH Month Day Year August 31 19 66					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 31, 1966		9. AGE (In years last birthday) yrs. Months Days 5 24		IF UNDER 1 YEAR IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Leonard Earl Kelley						14. MOTHER'S MAIDEN NAME Margie Louise Trader					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 7 76 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) C. Section Delivered In Ab. Plac										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/31, 1966 , to 8/31, 1966 , that (I) (we) last saw the deceased alive on 8/31 19 66 , and that death occurred at 235 M, from the causes and on the date stated above.											
22a. SIGNATURE D.S. Anderson						M.D. ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8/31/66	
22c. PHYSICIAN'S NAME (Type)						22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 31, 1966		23c. NAME OF CEMETERY OR CREMATORY Belle Haven		23d. LOCATION (City, town or county) (State) Belle Haven, Va					
24. FUNERAL DIRECTOR Myrtle Jones Mapp						25a. REC'D BY REGISTRAR SEP 7 1966		25b. REGISTRAR'S SIGNATURE Charles Judge			

13089

Wisconsin

Gallegos

Benjamin General Hospital

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12032
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <i>Wicomico</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Wicomico</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN 1b <i>7/23/66</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		d. STREET ADDRESS <i>RD #5, Crooked Oak Lane</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>PENINSULA General Hospital</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>BERTHA</i> Middle <i>MAE</i> Last <i>Kelley</i>		4. DATE OF DEATH Month <i>August</i> Day <i>23</i> Year <i>1966</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>July 14, 1898</i>
9. AGE (In years last birthday) <i>68</i> yrs.		10. IF UNDER 1 YEAR Months <i>1</i> Days <i>9</i>	
11. IF UNDER 24 HRS. Hours <i></i> Min. <i></i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <i>Wicomico Co., Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Benjamin Thomas Hearn</i>		14. MOTHER'S MAIDEN NAME <i>Alverta Mills</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>--</i>	
17. INFORMANT <i>Mr. Homer D. Kelley (Husband)</i> <i>RD #5, Salisbury, Maryland</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Vagina with</i> <i>1761</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>metastases to lungs</i> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <i>7/23</i> , 19 <i>66</i> , to <i>8/23</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/23</i> , 19 <i>66</i> , and that death occurred at <i>4:30</i> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <i>David J. Gilmore</i>		22b. DATE SIGNED <i>Aug. 23, 1966</i>	
22c. PHYSICIAN'S NAME (Type) <i>Dr. David J. Gilmore</i>		22d. ADDRESS <i>Salisbury, Maryland</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>August 26/66</i>	
23c. NAME OF CEMETERY OR CREMATORY <i>Parsons Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>	
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>AUG 25 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

1208

Commission

Shirley
Finnish in General Hospital

Kelly
August 22 44

Female white

4

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12033					12030				
1. PLACE OF DEATH a. COUNTY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE				
Wicomico MARYLAND					Maryland				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Salisbury					Ocean City				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM?				
PENINSULA GENERAL HOSPITAL					11th ST YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)			First Middle Last		4. DATE OF DEATH		Month Day Year		
Harry Palmer Kelly					August 21 1966				
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.		
MALE	White		FEB. 22, 1891		75 yrs.		Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?		
GASTGUARD, HOTEL			RETIRED		BERLIN MD		USA		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
EDWARD KELLY					ELLEN PAYNE				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT		Address		
YES World II					MR. H. W. KELLY		Ocean City MD		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4200 Arteriosclerosis heart Disease									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
19									
21. I certify that (I) (this hospital) attended the deceased from 8-11, 1966 to 8-21, 1966 that (I) (we) last saw the deceased alive on 8-21, 1966 and that death occurred at 5 AM, from the causes and on the date stated above.									
22a. SIGNATURE					22b. DATE SIGNED				
William R. Ellis					8-24-66				
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)		
Burial			8/24/66		Evergreen		Berlin Wic. MD		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Anna A. Burbyge					AUG 26 1966		J. Charles Judge		

18030

CERTIFICATE OF DEATH

18030

Deceased

John (General) H. H. H.

Henry H. H. H.

Male

Age

Color

Place of Birth

Occupation

Cause of Death

Time of Death

Place of Death

Signature

Date

Registrar

Witness

Signature

Date

Registrar

Witness

Signature

Date

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
12034									
12031									
1. PLACE OF DEATH a. COUNTY <u>Nicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Horn town</u> d. STREET ADDRESS <u>Box 39</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <u>FANNIE</u> First <u>Wallop</u> Middle <u>KNOX</u> Last			4. DATE OF DEATH <u>August 22</u> Month <u>1966</u> Day <u>19</u> Year						
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 18, 1894</u>		9. AGE (In years last birthday) <u>72</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edward Wallop</u>					14. MOTHER'S MAIDEN NAME <u>Ida Rue</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>William Knox Horntown, Va.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inter cerebral Hemorrhage</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-16</u> , 19 <u>66</u> to <u>8-23</u> , 19 <u>66</u> ; that (I) (we) last saw the deceased alive on <u>8-22</u> , 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>Joseph C. [Signature]</u> M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/24/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>Samuel S. [Signature]</u>					22d. ADDRESS <u>Midland Center Salisbury Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-28-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tabernacle Bapt. Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Horn town, Va.</u>			
24. FUNERAL DIRECTOR <u>Samuel S. [Signature]</u> ADDRESS <u>New Church, Va.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
					DATE <u>AUG 29 1966</u>				

15051

15051

CERTIFICATE OF DATA

Received of the Treasurer of the Town of
Bristol 8-28-20 the sum of \$100.00 for
the purchase of the land on which the
Bristol High School is located.

Witness my hand and seal this 28th day of August, 1920.

Edward Kelley
Mayor

Attest:
My Comm. Expires 12-31-20

John H. Kelley
Treasurer

Young
Hartman

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12035					12032				
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Somerset</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			c. LENGTH OF STAY IN 1b <i>5 weeks</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Crisfield</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>					d. STREET ADDRESS <i>Myrtle Street</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>RISSIE</i> Middle <i>J.</i> Last <i>Landon</i>		4. DATE OF DEATH Month <i>August</i> Day <i>23</i> Year <i>1966</i>							
5. SEX <i>FEMALE</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 18, 1877</i>	9. AGE (in years last birthday) <i>89</i>	IF UNDER 1 YEAR Months <i>19</i> Days <i>2</i>		IF UNDER 24 HRS. Hours <i>19</i> Min. <i>66</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Virginia</i>			12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		
13. FATHER'S NAME <i>William Obier</i>				14. MOTHER'S MAIDEN NAME <i>Elsie Dameron</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>		17. INFORMANT <i>Mitchell Landon, Conshohocken, Pa.</i>		Address <i>334 North Lane</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Esophagus</i> <i>150x</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on <i>7/20/1966</i> , and that death occurred at <i>12:40</i> AM, from the causes and on the date stated above.									
22a. SIGNATURE <i>[Signature]</i>				22b. DATE SIGNED					
22c. PHYSICIAN'S NAME (Type) <i>O. J. Burton</i>				22d. ADDRESS <i>Salisbury, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 25, 1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Sunnyridge Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Crisfield, Md.</i>			
24. FUNERAL DIRECTOR <i>Bradshaw & Sons, Crisfield, Md.</i>				25a. REC'D BY REGISTRAR <i>AUG 29 1966</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

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Composed

Originals

Originals

North Street

1877

Virginia

State of

Washington, D.C.

Calgary, Alta.

London

Calgary, Alta.

Aug. 22, 1905

Hotel

London & Co., Calgary, Alta.

ALL 1905

1905

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>						c. LENGTH OF STAY IN 1b <u>22-1</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>LAWRENCE</u> Last <u>LAWRENCE</u>			4. DATE OF DEATH Month <u>AUGUST</u> Day <u>6</u> Year <u>1966</u>								
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUGUST 5, 1966</u>		9. AGE (In years last birthday) yrs. <u>-</u> Months <u>-</u> Days <u>15</u> Min. <u>-</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico, Maryland</u>			
13. FATHER'S NAME <u>Unknown</u>						12. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u>						14. MOTHER'S MAIDEN NAME <u>CAROLYN FRANCES LAWRENCE</u>					
16. SOCIAL SECURITY NO. <u>-</u>						17. INFORMANT <u>CAROLYN LAWRENCE</u> Address <u>Quantico, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>7625 Atelectasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity Birth wt 1820 gms</u> (c) <u>-</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>-</u>											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>-</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>8/5</u> , 19 <u>66</u> , to <u>8/6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/6</u> , 19 <u>66</u> , and that death occurred at <u>1 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Alfred C. Kolls</u>						22b. DATE SIGNED <u>8/6/66</u>					
22c. PHYSICIAN'S NAME (Type) <u>ALFRED C. KOLLS</u>						22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>8/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Quantico</u>		23d. LOCATION (City, town or county) (State) <u>Quantico, Maryland</u>			
24. FUNERAL DIRECTOR <u>Christa Stewart</u>						25a. REC'D BY REGISTRAR <u>Schlesinger</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			
DATE <u>AUG 11 1966</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12037 CERTIFICATE OF DEATH 12034

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 403 Truitt Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Nora Ellen Layfield		4. DATE OF DEATH Month Day Year August 11 1966	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 15, 1884
9. AGE (In years last birthday) 82 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 2 26	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Laurel, Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Hastings		14. MOTHER'S MAIDEN NAME Fannie Records	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 302-875-3467	
17. INFORMANT Mrs. Pauline Hastings Massey 403 Truitt Street, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH 1 Day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) NA	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Aug 10, 1966 , to Aug 11, 1966 , that (I) (we) last saw the deceased alive on Aug 11 1966 , and that death occurred at 4:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Wilbur Ellis		22b. DATE SIGNED 8/12/66	
22c. PHYSICIAN'S NAME (Type) Dr. Wilbur Ellis		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 14, 66	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR Aug 15 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12038
12035
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 316 Charles Street		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 316 Charles Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Walter Leroy Llewellyn, Sr.		4. DATE OF DEATH Month Day Year August 11 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 31, 1887
9. AGE (In years last birthday) 78 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 7 10	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Mechanist		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Phoenixville, Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Llewellyn		14. MOTHER'S MAIDEN NAME Elizabeth --	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 161-03-0798-A	
17. INFORMANT Mrs. Minnie L. Llewellyn (wife) 316 Charles Street, Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the throat + mandible 1992 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 1 year	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/9 , 19 66 , to 8/11 , 19 66 , that (I) was last saw the deceased alive on 8/9 19 66 , and that death occurred at 6:50 A.M. from the causes and on the date stated above.			
22a. SIGNATURE George H. Henning		22b. DATE SIGNED August 12, 1966	
22c. PHYSICIAN'S NAME (Type) Dr. George H. Henning		22d. ADDRESS Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF August 15/66	
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		23d. LOCATION (City, town or county) (State) Philadelphia, Pennsylvania	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 15 1966 25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12039 CERTIFICATE OF DEATH 12036

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>none</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Alexandria</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>				e. STREET ADDRESS <u>417 E. Howell Avenue</u>			
3. NAME OF DECEASED (Type or print) First <u>WALLACE</u> Middle <u>Lunceford</u> Last <u>Lunceford</u>				4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1966</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 30, 1886</u>	
9. AGE (in years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General Car Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>R.F. & P. RR</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Delaplane, Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>John Henry Lunceford</u>				14. MOTHER'S MAIDEN NAME <u>Mary Levinia Lawrence</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>718-14-2993</u>			
17. INFORMANT Address <u>Alex. Mary W. Lunceford, 417 E. Howell Ave., Va.</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Coronary arteriosclerosis</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-16, 1966</u> to <u>8-18, 1966</u> , that (I) (we) last saw the deceased alive on <u>8-18, 1966</u> , and that death occurred at <u>6:45</u> A.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>James R. Clifford</u>				22b. DATE SIGNED <u>8-18-66</u>			
22c. PHYSICIAN'S NAME (Type) <u>JAMES R. CLIFFORD</u>				22d. ADDRESS <u>Medical Center Salisbury Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>Aug. 22, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ivy Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Alexandria Virginia</u>	
24. FUNERAL DIRECTOR <u>Everly-Wheatley Funeral Home</u>				25a. REC'D BY REGISTRAR <u>AUG 22 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>			

15033

CERTIFICATE OF DEATH

15033

name

Virginia

Albemarle

1001 N. 10th Street

March 30, 1966

1001 N. 10th Street, Albemarle, Virginia

U.S. & P. M.

General Burial

Harry Levinson

John Henry Levinson

7-11-2003 Harry H. Levinson, 1001 N. 10th St., Albemarle, Va.

Virginia

Albemarle

March 30, 1966

Final

15033

Albemarle, Va.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12040					12037				
Item 7 Film G379 8/12/66									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>New Church</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>New Church, Va.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>MARGARET</u> Middle <u>A.</u> Last <u>MARINER</u>			4. DATE OF DEATH Month <u>August</u> Day <u>5</u> Year <u>1966</u>						
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>6/14/1887</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>79</u> Days <u>79</u> Hours <u>79</u> Min. <u>79</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Accomack, Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>John Watson</u>					14. MOTHER'S MAIDEN NAME <u>Mary E. Thornton</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>225-40-49958</u>		17. INFORMANT <u>C. Lee Davis</u>		Address <u>New Church, Va.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Emboli</u> <u>4221</u> DUE TO (b) <u>Arteriosclerosis Cardiovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>2 yrs.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 19 <u>66</u> , to <u>8/5</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8/5</u> , 19 <u>66</u> , and that death occurred at <u>11:20</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>George H. Henning</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>George H. Henning</u>					22d. ADDRESS <u>Peninsula General Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/7/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nelsons Ceme.</u>			23d. LOCATION (City, town or county) (State) <u>New Church, Virginia</u>		
24. FUNERAL DIRECTOR <u>For Funeral Home Temperanceville, Va.</u>					25a. REC'D BY REGISTRAR <u>Charles Judge</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		
DATE <u>AUG 10 1966</u>									

1803

1803

STATE OF NEW YORK

[Faint, illegible text throughout the page, likely bleed-through from the reverse side.]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH				Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201			
12041				MEDICAL EXAMINER'S CERTIFICATE OF DEATH			
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Delaware b. COUNTY Sussex			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Frankford		46.3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hosp.				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) FRANCES		First Middle Last MASON		4. DATE OF DEATH Month 8 Day 7 Year 1966			
5. SEX Female	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-10-1919	9. AGE (In years last birthday) 47 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY none		11. BIRTHPLACE (State or foreign country) South Carolina		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Fred Daniels			14. MOTHER'S MAIDEN NAME Sadie Mills				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -		17. INFORMANT Mrs. Sadie Mills, Frankford, Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale 5271 DUE TO (b) Emphysema diffuse both lungs DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Badly fractured						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Ph. L. A. Insley		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED 8-12-66	
EXAMINER'S NAME (Type) Ph. L. A. Insley				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8-13-66		23c. NAME OF CEMETERY OR CREMATORY Antioch Cemetery		23d. LOCATION (City or Town) (County) (State) Frankford, Sussex, Del.	
24. FUNERAL DIRECTOR Charles Nelson		ADDRESS Frankford, Delaware		25a. REC'D BY REGISTRAR DATE AUG 15 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

1803

1803

PHOTOGRAPH

W. J. L. L.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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VR A15ME (5)
6M 1/66

12042

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12039

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs 22-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First GEORGE Middle W. Last MASSEY		4. DATE OF DEATH Month August Day 4 Year 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-31-07
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Delaware		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edwin T. Massey		14. MOTHER'S MAIDEN NAME Bertha A. Morris	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 219-14-3546	
17. INFORMANT Mrs. Martha Massey, Mardela, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure DUE TO (b) Arteriosclerotic cardio-vascular disease DUE TO (c) Diabetes Mellitus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH Minutes Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED August 5, 1966	
EXAMINER'S NAME (Type) 109 Camden Ave., Salisbury, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 8/7/1966	
23c. NAME OF CEMETERY OR CREMATORY Riverton		23d. LOCATION (City or Town) (County) (State) Mardela, Wicomico, Md.	
24. FUNERAL DIRECTOR Newman Funeral Home, Easton, Md.		25a. REC'D BY REGISTRAR DATE AUG 10 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

15080

15081

[Handwritten signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12043

12040

1. PLACE OF DEATH a. COUNTY WICOMICO b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN 1b 16 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) PENINSULA GENERAL HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Pocomoke City d. STREET ADDRESS 209 MARKET STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BLANCHE PAULINE MILES				4. DATE OF DEATH Month Day Year AUGUST 7 1966			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH JULY 5, 1890	
9. AGE (In years last birthday) 76 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) WORCESTER COUNTY, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALES CLERK				10b. KIND OF BUSINESS OR INDUSTRY RETAIL CLOTHING			
13. FATHER'S NAME ALEC G. JUSTICE				14. MOTHER'S MAIDEN NAME MARY FOSTER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 220-09-1135-A		17. INFORMANT WILLIAM A. MILES, Pocomoke City, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MI 6000 DUE TO (b) CHRONIC PEYLOMYELITIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7-22, 1966 to 8-7, 1966 , that (I) (we) last saw the deceased alive on 8-7, 1966 and that death occurred at 8:45 AM , from the causes and on the date stated above.							
22a. SIGNATURE W. R. Ellis, Jr.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-7-66	
22c. PHYSICIAN'S NAME (Type) W. R. ELLIS, JR., M.D.				22d. ADDRESS SALISBURY, MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8-9-1966		23c. NAME OF CEMETERY OR CREMATOR ST. MARY EPISCOPAL		23d. LOCATION (City, town or county) (State) Pocomoke City, Maryland	
24. FUNERAL DIRECTOR Robert H. Watson				25a. REC'D BY REGISTRAR Robert H. Watson		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					d. STREET ADDRESS <u>Route #1</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last (DINK) <u>Jesse HARVEY MILLER</u>					4. DATE OF DEATH Month Day Year <u>AUGUST 5, 1966</u>				
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 25/1914</u>		9. AGE (in years last birthday) <u>52 yrs.</u> IF UNDER 1 YEAR: Months <u>6</u> Days <u>10</u> IF UNDER 24 HRS: Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner - Taxi Co.</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Taxi</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Bowling Green, Florida</u>			12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Samuel C. Miller</u>					14. MOTHER'S MAIDEN NAME <u>Margaret M. Altman</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>YES W.W.#II</u>			16. SOCIAL SECURITY NO. <u>220-03-4911</u>		17. INFORMANT Address <u>Mrs. Betty R. Miller (Wife) R.D.#1 (St. Luke Rd) Salisbury, Maryland 21801</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE: <u>Ventricular Fibrillation</u> <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Antero-septal myocardial infarction</u> (c) <u>17 days.</u>								INTERVAL BETWEEN ONSET AND DEATH <u>45 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1960</u> , 19 <u> </u> , to <u>Aug 5</u> , 19 <u>66</u> , that (I)-(we) last saw the deceased alive on <u>Aug 5</u> , 19 <u>66</u> , and that death occurred at <u>7:35</u> M, from the causes and on the date stated above.									
22a. SIGNATURE <u>Robert T. Adkins</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> M.D. <u>DR. Robert T. Adkins</u>			22b. DATE SIGNED <u>5 Aug 66</u>	
22c. PHYSICIAN'S NAME (Type) <u>DR. Robert T. Adkins</u>					22d. ADDRESS <u>Fruitland, Maryland</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Aug. 9/1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>			23d. LOCATION (City, town or county) (State) <u>Salisbury Maryland</u>		
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>					25a. REC'D BY REGISTRAR <u>AUG 9 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

12041

(DIME)

Jan. 25, 1914

Bowling Green, Florida U.S.A.

Owner - Taxi Co.

Samuel G. Miller

Mr. Robert H. Miller (Wife H.D. I)
220-02-4041 (St. Lake Rd) Salisbury, Maryland 21061

Dr. Robert T. Atkins

Barrel and 9/1966

WOLLMAN & COMPANY SALISBURY, MARYLAND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item #8 Film #G380 8/24/66 pc

12045

CERTIFICATE OF DEATH

12042

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 12 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.			d. STREET ADDRESS Crisfield Lane		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last Thomas David Nicholls			4. DATE OF DEATH Month Day Year 8 15 66		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1911 JAN. 20, 1920	9. AGE (In years last birthday) 55 yrs.	IF UNDER 1 YEAR Months Days Hours Min. 5 4 16
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) POULTRY		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) SCRANTON, PA.	
13. FATHER'S NAME THOMAS D. NICHOLLS			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			14. MOTHER'S MAIDEN NAME SARAH ANNE HUGHES		
16. SOCIAL SECURITY NO.			17. INFORMANT MRS NAOMIE B. NICHOLLS Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 178X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Seminoma with pulmonary and spinal metastases (c) and spinal metastases			PRINCESS ANNE, MD. INTERVAL BETWEEN ONSET AND DEATH 5-7 days 9-16 mos		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 8/3 , 19 66 , to 8/15 , 19 66 , that (I) (we) last saw the deceased alive on 8/15 , 19 66 , and that death occurred at 6:10 M, from causes and on the date stated above.					
22a. SIGNATURE C. H. Winnacott			22b. DATE SIGNED 8/16/66		
22c. PHYSICIAN'S NAME (Type) C. H. Winnacott, M. D.			22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.		
23a. BURIAL, CREMATION, BURIAL		23b. DATE THEREOF 8-18-1966		23c. NAME OF CEMETERY OR CREMATORY OLIVER T. BEECHWOOD CEM. PRINCESS ANNE, MD.	
23d. LOCATION (City or Town)		23e. (County)		23f. (State)	
24. FUNERAL DIRECTOR LEVIN R. WILSON			25. REG'D BY REGISTRAR Aug 19 1966		
26. ADDRESS PRINCESS ANNE, MD.			27. REGISTRAR'S SIGNATURE Charles Judge		

15043

15043

JAN. 20, 1900

WASHINGTON, D.C.

THOMAS D. NICHOLS
MRS. NICHOLS B. NICHOLS
PRINCES ANNE, MD.

THOMAS D. NICHOLS

8-18-1888 OLIVER T. BECKWOOD GUN. PRINCES ANNE, MD.

LEVIN R. WILSON PRINCES ANNE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 4-64

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12046 CERTIFICATE OF DEATH 12043									
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar				c. LENGTH OF STAY IN 1b 88 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar 22-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 420 E.State St,						d. STREET ADDRESS 420 E.State		e. IS RESIDENCE DN A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ENOLA Middle MAE Last PHILLIPS			4. DATE OF DEATH Month Aug. Day 9, Year 1966						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 26, 1877		9. AGE (In years last birthday) 88 IF UNDER 1 YEAR: Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS: Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Delmar, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Burton LeCates					14. MOTHER'S MAIDEN NAME Letitia Hearn				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. -----		17. INFORMANT Lillian Bryant, Delmar, Md.			Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) arteriosclerotic Heart Disease OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Severe gastroduodenal hemorrhage of unknown etiology								INTERVAL BETWEEN ONSET AND DEATH 6 mos 5 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 5/10, 1960 to death , 19 66 , that (I) (we) last saw the deceased alive on Aug 8, 1966 , and that death occurred at 6:10 PM , from the causes and on the date stated above.									
22a. SIGNATURE Ernest Larmore M.O.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8-10-66		
22c. PHYSICIAN'S NAME (Type) Dr. Ernest M. Larmore					22d. ADDRESS Delmar, Del.				
23a. BURIAL CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 8-12-66		23c. NAME OF CEMETERY OR CREMATORY St. Stephens		23d. LOCATION (City, town or county) (State) Delmar, Del.		
24. FUNERAL DIRECTOR Charles W. Marvel, Delmar, Del.					25a. REC'D BY REGISTRAR DATE AUG 12 1966		25b. REGISTRAR'S SIGNATURE J. Charles Judge		

12044

12044

Wisconsin

Wisconsin

Wisconsin

Belmont

Belmont

12044

12044

Belmont

Belmont

Aug. 24, 1917

White

USA

Belmont, Mo.

At home

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Belmont, Mo.

Aug. 10, 1922

Belmont, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Ocean City</u> d. STREET ADDRESS <u>R. F. D</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last <u>Hermine LILLIAN Price</u>					4. DATE OF DEATH Month Day Year <u>August 8 1966</u>				
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>FEB. 4, 1909</u>		9. AGE (In years last birthday) <u>57</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>BAMBERG S.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>CLARENCE MC MILLAN</u>					14. MOTHER'S MAIDEN NAME <u>CARRIE SMITH</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT Address <u>MR. JAMES PRICE, OCEAN CITY MD</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>8-7</u> , 19 <u>66</u> to <u>8-8</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>8-8</u> , 19 <u>66</u> and that death occurred at <u>7:50</u> AM, from the causes and on the date stated above.									
22a. SIGNATURE <u>William R. Ellis, Jr.</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> M.O. <input type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8-8-66</u>
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>8/11/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. PAULS EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>BELLEVILLE MD</u>			
24. FUNERAL DIRECTOR <u>Anna R. Burdette Berlin Ind.</u>					25a. REC'D BY REGISTRAR DATE <u>AUG 12 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

CERTIFICATE OF DEATH

12041

Deceased
Oscar D. J.
1910

On the 1st day of August 1910
at the City of New York
I, the undersigned, being a duly qualified
physician, do hereby certify that
the within and above named
person has died at the City of New York
at the residence of the deceased.

Witness my hand and seal this 1st day of August 1910.
J. H. [Signature]
Physician

Attest:
[Signature]
City Clerk

Filed for record this 1st day of August 1910.
[Signature]
City Clerk

12048

CERTIFICATE OF DEATH

12045

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b since 8/5/66	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		d. STREET ADDRESS 120 N. Somerset Avenue	
3. NAME OF DECEASED (Type or print) First Middle Last Ralph - Riggins		4. DATE OF DEATH Month Day Year August 21 19 66	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 21, 1877
9. AGE (In years lost birthday) 89 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seafood Dealer		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (County & State, or foreign country) Somerset Co., Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Thomas Riggins		14. MOTHER'S MAIDEN NAME Mary Riggins	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 219-34-3307	
17. INFORMANT Records of Pine Bluff State Hospital, Salisbury, Md.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Tuberculosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) senile degeneration		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 5 , 19 66 , to Aug. 21 19 66 that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on Aug. 21 19 66 , and that death occurred at 11 PM , from causes and on the date stated above.			
22a. SIGNATURE E. P. Ritchings		22b. DATE SIGNED Aug. 22, 1966	
22c. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.		22d. ADDRESS Pine Bluff State Hospital Salisbury, Maryland-21801	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8/24/1966	23c. NAME OF CEMETERY OR CREMATORY Sunnyridge	23d. LOCATION (City or Town) (County) (State) Hopewell Somerset, Md.
24. FUNERAL DIRECTOR James Herman		25a. REC'D BY REGISTRAR DATE AUG 26 1966	
ADDRESS Crisfield, Md.		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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24031

b. 10/18/10

coincide.

2411474

04/2/88

2411474

1997-1998 2000-2001 2002-2003 2004-2005 2006-2007 2008-2009 2010-2011 2012-2013 2014-2015 2016-2017 2018-2019 2020-2021 2022-2023 2024-2025 2026-2027 2028-2029 2030-2031 2032-2033 2034-2035 2036-2037 2038-2039 2040-2041 2042-2043 2044-2045 2046-2047 2048-2049 2050-2051 2052-2053 2054-2055 2056-2057 2058-2059 2060-2061 2062-2063 2064-2065 2066-2067 2068-2069 2070-2071 2072-2073 2074-2075 2076-2077 2078-2079 2080-2081 2082-2083 2084-2085 2086-2087 2088-2089 2090-2091 2092-2093 2094-2095 2096-2097 2098-2099 2100-2101 2102-2103 2104-2105 2106-2107 2108-2109 2110-2111 2112-2113 2114-2115 2116-2117 2118-2119 2120-2121 2122-2123 2124-2125 2126-2127 2128-2129 2130-2131 2132-2133 2134-2135 2136-2137 2138-2139 2140-2141 2142-2143 2144-2145 2146-2147 2148-2149 2150-2151 2152-2153 2154-2155 2156-2157 2158-2159 2160-2161 2162-2163 2164-2165 2166-2167 2168-2169 2170-2171 2172-2173 2174-2175 2176-2177 2178-2179 2180-2181 2182-2183 2184-2185 2186-2187 2188-2189 2190-2191 2192-2193 2194-2195 2196-2197 2198-2199 2200-2201 2202-2203 2204-2205 2206-2207 2208-2209 2210-2211 2212-2213 2214-2215 2216-2217 2218-2219 2220-2221 2222-2223 2224-2225 2226-2227 2228-2229 2230-2231 2232-2233 2234-2235 2236-2237 2238-2239 2240-2241 2242-2243 2244-2245 2246-2247 2248-2249 2250-2251 2252-2253 2254-2255 2256-2257 2258-2259 2260-2261 2262-2263 2264-2265 2266-2267 2268-2269 2270-2271 2272-2273 2274-2275 2276-2277 2278-2279 2280-2281 2282-2283 2284-2285 2286-2287 2288-2289 2290-2291 2292-2293 2294-2295 2296-2297 2298-2299 2300-2301 2302-2303 2304-2305 2306-2307 2308-2309 2310-2311 2312-2313 2314-2315 2316-2317 2318-2319 2320-2321 2322-2323 2324-2325 2326-2327 2328-2329 2330-2331 2332-2333 2334-2335 2336-2337 2338-2339 2340-2341 2342-2343 2344-2345 2346-2347 2348-2349 2350-2351 2352-2353 2354-2355 2356-2357 2358-2359 2360-2361 2362-2363 2364-2365 2366-2367 2368-2369 2370-2371 2372-2373 2374-2375 2376-2377 2378-2379 2380-2381 2382-2383 2384-2385 2386-2387 2388-2389 2390-2391 2392-2393 2394-2395 2396-2397 2398-2399 2400-2401 2402-2403 2404-2405 2406-2407 2408-2409 2410-2411 2412-2413 2414-2415 2416-2417 2418-2419 2420-2421 2422-2423 2424-2425 2426-2427 2428-2429 2430-2431 2432-2433 2434-2435 2436-2437 2438-2439 2440-2441 2442-2443 2444-2445 2446-2447 2448-2449 2450-2451 2452-2453 2454-2455 2456-2457 2458-2459 2460-2461 2462-2463 2464-2465 2466-2467 2468-2469 2470-2471 2472-2473 2474-2475 2476-2477 2478-2479 2480-2481 2482-2483 2484-2485 2486-2487 2488-2489 2490-2491 2492-2493 2494-2495 2496-2497 2498-2499 2500-2501 2502-2503 2504-2505 2506-2507 2508-2509 2510-2511 2512-2513 2514-2515 2516-2517 2518-2519 2520-2521 2522-2523 2524-2525 2526-2527 2528-2529 2530-2531 2532-2533 2534-2535 2536-2537 2538-2539 2540-2541 2542-2543 2544-2545 2546-2547 2548-2549 2550-2551 2552-2553 2554-2555 2556-2557 2558-2559 2560-2561 2562-2563 2564-2565 2566-2567 2568-2569 2570-2571 2572-2573 2574-2575 2576-2577 2578-2579 2580-2581 2582-2583 2584-2585 2586-2587 2588-2589 2590-2591 2592-2593 2594-2595 2596-2597 2598-2599 2600-2601 2602-2603 2604-2605 2606-2607 2608-2609 2610-2611 2612-2613 2614-2615 2616-2617 2618-2619 2620-2621 2622-2623 2624-2625 2626-2627 2628-2629 2630-2631 2632-2633 2634-2635 2636-2637 2638-2639 2640-2641 2642-2643 2644-2645 2646-2647 2648-2649 2650-2651 2652-2653 2654-2655 2656-2657 2658-2659 2660-2661 2662-2663 2664-2665 2666-2667 2668-2669 2670-2671 2672-2673 2674-2675 2676-2677 2678-2679 2680-2681 2682-2683 2684-2685 2686-2687 2688-2689 2690-2691 2692-2693 2694-2695 2696-2697 2698-2699 2700-2701 2702-2703 2704-2705 2706-2707 2708-2709 2710-2711 2712-2713 2714-2715 2716-2717 2718-2719 2720-2721 2722-2723 2724-2725 2726-2727 2728-2729 2730-2731 2732-2733 2734-2735 2736-2737 2738-2739 2740-2741 2742-2743 2744-2745 2746-2747 2748-2749 2750-2751 2752-2753 2754-2755 2756-2757 2758-2759 2760-2761 2762-2763 2764-2765 2766-2767 2768-2769 2770-2771 2772-2773 2774-2775 2776-2777 2778-2779 2780-2781 2782-2783 2784-2785 2786-2787 2788-2789 2790-2791 2792-2793 2794-2795 2796-2797 2798-2799 2800-2801 2802-2803 2804-2805 2806-2807 2808-2809 2810-2811 2812-2813 2814-2815 2816

08 555 123 456 789

XQZ-47-918

参考文献

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• 1998 •

Cryptosporidium Oocysts

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

12049

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12046

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>N.Y.</u> b. COUNTY <u>✓</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN lb <u>250A</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Jonawanda</u>		19-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>J</u> Last <u>Sackey Jr.</u>				4. DATE OF DEATH Month <u>8</u> Day <u>13</u> Year <u>1966</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>W.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-16-46</u>	
9. AGE (In years last birthday) <u>19</u> yrs.		IF UNDER 1 YEAR Months <u>1</u> Days <u>13</u>		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Air Force</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Air Force</u>		11. BIRTHPLACE (State or foreign country) <u>N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Joseph J. Sackey Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Dorothy Whipple</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u>		16. SOCIAL SECURITY NO. <u>111-38-0928</u>		17. INFORMANT <u>Air Force</u>		Address <u>Dover, Del.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> DUE TO (b) <u>8254</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Crushed chest</u> DUE TO (b) <u>Crushed chest</u> DUE TO (c) <u>Crushed chest</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Crushed chest</u>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>one car accident</u>					
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>12:50</u> p.m. <u>8-13</u> 19 <u>66</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Route 13</u>		20f. (City or town) <u>Salisbury</u> (County) <u>md.</u> (State) <u>md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Charles Farley</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Ph. P. A. Insley</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-18-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		23d. LOCATION (City or Town) (County) (State) <u>Jonawanda N.Y.</u>	
24. FUNERAL DIRECTOR <u>William J. Eckman</u>				ADDRESS <u>Georgetown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 29 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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CERTIFICATE OF DEATH

12047

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN lb 33 days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS Preston	
3. NAME OF DECEASED (Type or print) First Ruth Middle Amelia Last Schmick		4. DATE OF DEATH Month Aug. Day 13 Year 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 21, 1895
9. AGE (In years last birthday) yrs. 71		IF UNDER 1 YEAR Months 13 Days 19 Hours 66 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (County & State, or foreign country) Accident, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Gustav Goehringer		14. MOTHER'S MAIDEN NAME Anna Giessmann	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 218-10-8993	
17. INFORMANT Lawrence Schmick, Preston, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary thrombosis DUE TO (b) Hypertensive arteriosclerotic cardiovascular disease DUE TO (c) disease			INTERVAL BETWEEN ONSET AND DEATH 9 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Old fracture, right hip - surgical reduction			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 Month, Day, Year p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (this hospital) attended the deceased from 7/11, 19 66 , to Aug. 13, 19 66 , that (we) saw the deceased alive on Aug. 13, 19 66 , and that death occurred at M , from causes and on the date stated above.			
22a. SIGNATURE Charles H. Winnacott M.D.		22b. DATE SIGNED 8/13/66	
22c. PHYSICIAN'S NAME (Type) Charles H. Winnacott, M.D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Aug. 16, 1966	23c. NAME OF CEMETERY OR CREMATORY Junior Order Cemetery	23d. LOCATION (City or Town) (County) (State) Preston, Maryland
24. FUNERAL DIRECTOR J. J. Frampton and Son, Federalsburg, Maryland		25a. REC'D BY REGISTRAR Aug 18 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15041

CERTIFICATE OF BIRTH

15041

July 21, 1922

USA

Accident, Maryland

None

Housework

Anna Clemons

Edward Goshinger

Lawrence Schmidt, Preston, Maryland

715-10-2992

No

Anna Clemons

Edward Goshinger

Accident

Lawrence Schmidt - Preston, Maryland

Preston, Maryland

July 10, 1922 Junior Order Cemetery

Smith

Edward Goshinger, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12051 CERTIFICATE OF DEATH 12048											
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u>						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. LENGTH OF STAY IN 1b <u>3 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tylerton</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS <u>Rural</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>ELIZABETH</u> Middle <u>L.</u> Last <u>SMITH</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1966</u>								
5. SEX <u>Female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 1, 1887</u>		9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Crisfield, Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>William Landon</u>					14. MOTHER'S MAIDEN NAME <u>Julia Charnick</u>						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mr. Jerome Smith, Same as 2. abcd</u>			Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> 4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis Coronary Artery</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I (this hospital) attended the deceased from <u>8-18</u> , 19 <u>66</u> , to <u>8-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-20</u> 19 <u>66</u> , and that death occurred at <u>30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Nevin W. Todd, Jr.</u>					22b. DATE SIGNED M.D. <input type="checkbox"/> ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						
22c. PHYSICIAN'S NAME (Type) <u>Nevin W. Todd, Jr.</u>					22d. ADDRESS <u>Salisbury, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Aug. 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tylerton Cemetery</u>			23d. LOCATION (City, town or county) (State) <u>Tylerton, Md.</u>			
24. FUNERAL DIRECTOR <u>Bradshaw & Sons, Crisfield, Md.</u>					25a. REC'D BY REGISTRAR OAT <u>AUG 25 1966</u>					25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>12049</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millsboro</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>2nd St.</u>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Smith</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>August</u> Day <u>27</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 14 1918</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>4</u> Days <u>8</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>factory</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Accomack Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John H. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Bessie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes give war or dates of service) <u>war II</u>		16. SOCIAL SECURITY NO. <u>4201</u>	
17. INFORMANT <u>Archie Smith - Millsboro, Del.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> 4201 DUE TO (b) <u>Coronary atherosclerosis</u> DUE TO (c) <u>Severe hypertension vascular disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>YES.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Severe hypertension vascular disease</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. AGGIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>8-25</u> , 1966, to <u>8-27</u> , 1966, that (I) (we) last saw the deceased alive on <u>8-26</u> 1966, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Charles R. Thute, Jr.</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Samuel Savage</u>		22d. ADDRESS <u>New Church, Va.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Sept. 4, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Shiloh Baptist</u>		23d. LOCATION (City, town or county) (State) <u>Farmington, Va.</u>	
24. FUNERAL DIRECTOR <u>Samuel Savage</u>		25a. REG'D BY REGISTRAR <u>SEP 1 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

12/11/11

Wilhelms
2nd Lt.

July 14 1918 48

John

Factor

John H. Smith

See note II

James Smith - Wilhelms, Del.
George
Accompanying Virginia 424

General James Smith, Del.
James Smith, Del.
James Smith, Del.

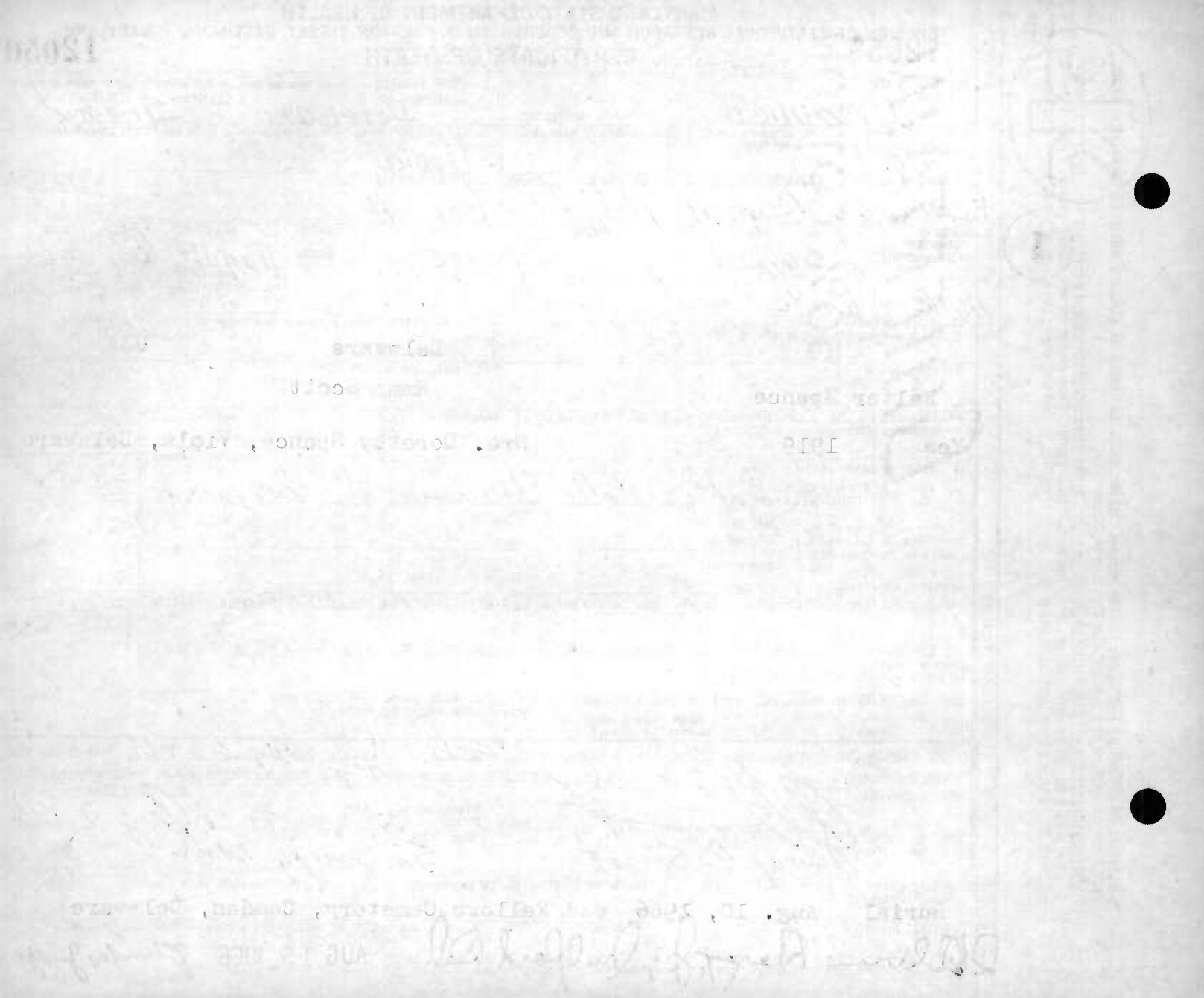
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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12053 Item 2b File # 12053 Items #8 & 9 File # 12053
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12050

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Sussex</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Viola</u> d. STREET ADDRESS <u>Box H</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Lemuel</u> Middle <u>Spence</u> Last <u>Spence</u>		4. DATE OF DEATH Month <u>August</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 6, 1898</u>
9. AGE (in years last birthday) <u>67</u> yrs.		10. UNDER 1 YEAR Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min.	11. UNDER 24 HRS. Months <u>6</u> Days <u>1</u> Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) <u>Delaware</u>
13. FATHER'S NAME <u>Walter Spence</u>		14. MOTHER'S MAIDEN NAME <u>Emma Scott</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>1919</u>		16. SOCIAL SECURITY NO. <u>1919</u>	
17. INFORMANT <u>Mrs. Dorothy Spence, Viola, Delaware</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Larynx</u> 161X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>DUE TO</u> (c) <u>DUE TO</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Feb</u> , 19 <u>66</u> , to <u>Aug 6</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 6</u> , 19 <u>66</u> , and that death occurred at <u>2:27</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Hubrey C. Smoot</u>		22b. DATE SIGNED <u>Aug 7, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Hubrey C. Smoot</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Aug. 10, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Odd Fellows Cemetery, Camden, Delaware</u>
23d. LOCATION (City, town or county) (State)			
24. FUNERAL DIRECTOR <u>William Berry, Jr., Milford, Del.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE			



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(M)
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12054 CERTIFICATE OF DEATH 12051											
Items 2, 8, 9 Film 0380 8/14/66											
1. PLACE OF DEATH a. COUNTY <u>Nicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>S. C.</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mount Pleasant</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>Nathan</u> First Middle Last 4. DATE OF DEATH <u>August 20</u> 19 <u>66</u> Month Day Year				5. SEX <u>MALE</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>7/6/1904</u> 9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>unknown</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>unknown</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Unknown</u> 12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <u>Jacob Swinton</u> 14. MOTHER'S MAIDEN NAME <u>Rosa Smith</u>							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT <u>P.S. Johnson</u> Address <u>mt. Pleasant S. Carolina</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinomatous</u> 157X DUE TO <u>Ca of head of Pancreas.</u> Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) (c)										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>66</u> , to <u>8-20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-20</u> 19 <u>66</u> , and that death occurred at <u>9 P.</u> M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Joseph C. Fitzgerald, M.D.</u> 22b. DATE SIGNED <u>8/24/66</u> 22c. PHYSICIAN'S NAME (Type) <u>JOSEPH C. FITZGERALD</u> 22d. ADDRESS <u>Medical Center, Salisbury, Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>8/24</u> 23b. DATE THEREOF 23c. NAME OF CEMETERY OR CREMATORY <u>mt. Pleasant Cern</u> 23d. LOCATION (City, town or county) (State) <u>mt. Pleasant S.C.</u>											
24. FUNERAL DIRECTOR <u>Booker West</u> ADDRESS <u>Funeral Home</u> 25a. REC'D BY REGISTRAR <u>SEP 2 1966</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>											

12021

12021



[Faint, mostly illegible handwritten text, possibly bleed-through from the reverse side of the page.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12055 CERTIFICATE OF DEATH 12052

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>408 Linden Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Lubertha</u>		4. DATE OF DEATH <u>August 20 1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 4, 1894</u>
9. AGE (In years, last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Levi H. James</u>		14. MOTHER'S MAIDEN NAME <u>Cordelia Kitchen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-14-6455</u>	
17. INFORMANT <u>Leona James</u>		Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>wound abscess.</u> 154X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic carcinoma of rectum.</u> OUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>arteriosclerotic cardiovascular disease.</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>none</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>none</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>None</u> 19 <u>66</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>None</u>		20f. (City or town) (County) (State) <u>None</u>	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15, 1966</u> , to <u>Aug 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>8/20 1966</u> , and that death occurred at <u>6 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Fred R. Eilber</u>		22b. DATE SIGNED <u>8/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>FRED R. EILBER</u>		22d. ADDRESS <u>Peninsula General Hosp.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8-23-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Pocomoke City, Md.</u>	
24. FUNERAL DIRECTOR <u>Samuel Sayer</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>New Church, Va.</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15025

STATEMENT OF DEATH

15025

West

MD

Frederick City

408 Jackson Ave

1924

1924

MD

Frederick

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Frederick City

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Frederick City

Frederick City

Frederick City

FRED R. ELLER

Frederick City

Frederick City

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12056					12053				
1. PLACE OF DEATH a. COUNTY <i>WICOMICO</i> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i> b. COUNTY <i>Wicomico</i>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>SALISBURY</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>NANTICKE (RURAL) 22-1</i>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>PENINSULA GENERAL HOSPITAL</i>					d. STREET ADDRESS <i>22-1</i>				
3. NAME OF DECEASED (Type or print) First Middle Last <i>HARRY HARDSTY THOMAS</i>					4. DATE OF DEATH Month Day Year <i>AUGUST 9 1966</i>				
5. SEX <i>MALE</i>		6. COLOR OR RACE <i>WHITE</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>SEPT 2 1889</i>		9. AGE (In years last birthday) <i>76</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>STORE KEEPER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>MERCHANT</i>		11. BIRTHPLACE (County & State, or foreign country) <i>VIRGINIA</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>			
13. FATHER'S NAME <i>GEORGE THOMAS</i>				14. MOTHER'S MAIDEN NAME <i>MARY CROCKETT</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>				16. SOCIAL SECURITY NO.		17. INFORMANT <i>MR. George Thomas</i> Address <i>Route 1 Salisbury, Md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Renal insufficiency</i> <i>6000</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic pyelonephritis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ASCVD</i>								INTERVAL BETWEEN ONSET AND DEATH <i>2 WK.</i> <i>YEARS</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>7-27, 1966</i> to <i>8-9, 1966</i> , that (I) (we) last saw the deceased alive on <i>8-8, 1966</i> , and that death occurred at <i>7:25</i> M, from the causes and on the date stated above.									
22a. SIGNATURE <i>Hubert L. White Jr.</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE THEREOF <i>8-11-1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wicomico Mem. Park</i>		23d. LOCATION (City, town or county) (State) <i>SALISBURY Md.</i>			
24. FUNERAL DIRECTOR <i>Thomas F. Wallace</i>				ADDRESS <i>SALISBURY, Md</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
DATE <i>AUG 11 1966</i>									

12052

12052

UNITED STATES DEPARTMENT OF AGRICULTURE

Division of Entomology

Washington, D. C.

REPORT

ON THE

INSECT

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OF THE

UNITED STATES

AND

ALASKA

AND

THE

INDIAN TERRITORIES

AND

THE

ISLANDS

OF THE PACIFIC

AND

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>		c. LENGTH OF STAY IN ID <i>July 25, 1966</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>Maryland</i>		b. COUNTY <i>Wicomico</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>						d. STREET ADDRESS <i>RFD 5, Quantico Rd.</i>			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print)		First <i>William</i>		Middle <i>Mayhew</i>		Last <i>Toadvine</i>		4. DATE OF DEATH Month <i>August</i>		Day <i>2</i> Year <i>1966</i>	
5. SEX <i>male</i>		6. COLOR OR RACE <i>white</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 3, 1891</i>		9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months <i>2</i> Days <i>29</i> Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired Farmer</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Farming</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Wicomico County Maryland</i>			12. CITIZEN OF WHAT COUNTRY? <i></i>		
13. FATHER'S NAME <i>Theodore F. Toadvine</i>						14. MOTHER'S MAIDEN NAME <i>Annie Hall</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>				16. SOCIAL SECURITY NO. <i>214-42-9563</i>		17. INFORMANT <i>Mr. William E. Toadvine (Son)</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) (same as #2)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary edema</i> DUE TO (b) <i>Metastasis to the liver</i> DUE TO (c) <i>Cedeno carcinoma of the colon</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>N/A</i>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>N/A</i>							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m. <i></i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>		20f. (City or town) (County) (State) <i></i>			
21. I certify that (I) (this hospital) attended the deceased from <i>7/25</i> , 19 <i>66</i> , to <i>8/2</i> , 19 <i>66</i> , that (I) (two) last saw the deceased alive on <i>8/2</i> , 19 <i>66</i> , and that death occurred at <i>3:50</i> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>George H. Henning</i>								22b. DATE SIGNED <i>8-2-66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Dr. George H. Henning</i>								22d. ADDRESS <i>Salisbury, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 5/66</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Parsons</i>				23d. LOCATION (City, town or county) (State) <i>Salisbury, Maryland</i>			
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY</i>						ADDRESS <i>SALISBURY MARYLAND</i>		25a. REC'D BY REGISTRAR <i>AUG 4 1966</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

13054

13057

Albion

Albion

Albion

July 22, 1886

And S. Albion

William W. W. W.

May 3, 1891

Albion County, N.Y.

Albion

Albion

Albion

Albion

Albion (200)

No

Albion, N.Y.

Dr. George H. Bennett

Albion, N.Y.

Albion, N.Y.

Albion

Albion, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
12058						12055					
1. PLACE OF DEATH a. COUNTY						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE					
Wicomico						MARYLAND					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)						c. LENGTH OF STAY IN 1b					
Salisbury						23-2					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						d. STREET ADDRESS					
Peninsula General						R.F.D.					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
Jesse M. Turner						August 25 1966					
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR IF UNDER 24 HRS.	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		MAR. 20, 1898		68 yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (County & State, or foreign country)			
FARMER				OWN FARM				BERLIN MD			
13. FATHER'S NAME						14. MOTHER'S MAIDEN NAME					
JESSE TRUITT						ELVA TOWNSEND					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No				No		Mrs Jesse M. Turner		OCEAN CITY MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory insufficiency</u> 3561 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory muscle palsy</u> DUE TO (c) <u>Myotrophic lateral sclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 8/13/66, 1966, to 8/25, 1966, that (I) (we) last saw the deceased alive on 8/25, 1966, and that death occurred at 1:00 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Richard E. Hughes				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial				8/27/66		EVERGREEN		BERLIN Wic. MD			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE							
Anna A. Burroughs				DATE AUG 30 1966 Charles J. J.							

12059

12059

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

City of ...

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20 M 1/66

12059

CERTIFICATE OF DEATH

12056

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Somerset		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN Tb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fairmount	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.			d. STREET ADDRESS Box 37		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Shirley Middle Mae Last Washington			4. DATE OF DEATH Month 8 Day 6 Year 19 66		
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 1920 April 13, 1919	9. AGE (In years last birthday) yrs. 46	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DOMESTIC		10b. KIND OF BUSINESS OR INDUSTRY INDUSTRY		11. BIRTH PLACE (County & State, or foreign country) Franklin VA.	
13. FATHER'S NAME Thomas Johnson			14. MOTHER'S MAIDEN NAME Rosetta Smith		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO. 217-28-2828		17. INFORMANT William Washington Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) Bronchogenic Carcinoma (adeno-carcinoma) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 10 wks ?					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pathological fracture right humerus - metastatic lesion					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from 8/3 , 19 66 , to 8/6 , 19 66 , that (I) (we) last saw the deceased alive on 8/6 , 19 66 , and that death occurred at 3:40 A.M. , from causes and on the date stated above.					
22a. SIGNATURE A. C. Mitchell			M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 8/8/66
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.			22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 8/10/66		23c. NAME OF CEMETERY OR CREMATORY Centennial	
23d. LOCATION (City or Town) Fairmount		(County)		(State) MD	
24. FUNERAL DIRECTOR Anthony E. Ward			25a. REC'D BY REGISTRAR Charles Judge		25b. REGISTRAR'S SIGNATURE Charles Judge
DATE AUG 11 1966					

15050

CERTIFICATE OF DEATH

15050

James J. Smith
Blackie Smith
14-12-1917, 40
Franklin St.
City of Columbia, Washington

James J. Smith
Blackie Smith
14-12-1917, 40
Franklin St.
City of Columbia, Washington

CERTIFICATE OF DEATH

12057

12060

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 16 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		d. STREET ADDRESS Box 298	
3. NAME OF DECEASED (Type or print) First Middle Last Rhuel E. Watts		4. DATE OF DEATH Month Day Year 8 25 19 66	
5. SEX Male	6. COLOR OR RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 4-14-02
9. AGE (In years lost birthday) 64 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic	
11. BIRTHPLACE (County & State, or foreign country) Wicomico, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Lena Watts	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 197-10-9607	
17. INFORMANT Hosp. Records		Address Salisbury, Maryland	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEUKEMIA - 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Hypertensive Crisis & cerebral DUE TO (c) Cerebral Vascular Disease.		INTERVAL BETWEEN ONSET AND DEATH 6 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) BRONCHO-PNEUMONIA		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
21. I certify that (I) (this hospital) attended the deceased from 8/9 , 19 66 , to 8/25 , 19 66 that (I) (we) last saw the deceased alive on 8/25 , 19 66 , and that death occurred at 7:25 AM , from causes and on the date stated above.		20f. (City or town) (County) (State)
22a. SIGNATURE C. M. Winnacott		22b. DATE SIGNED 8/25/66
22c. PHYSICIAN'S NAME (Type) C. M. Winnacott, M.D. Deer's Head State Hospital, Salisbury		22d. ADDRESS
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-29-66	23c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery
23d. LOCATION (City or Town) (County) (State) Wicomico, Md.		23e. REC'D BY REGISTRAR James B. Blashill
23f. REGISTRAR'S SIGNATURE Charles Judge		23g. DATE AUG 31 1966

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15057

12060

CONTRACT OF SALE

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12061

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12058

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (rural)		c. LENGTH OF STAY IN lb Delmar	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pemberton Drive Ext. (Esham Farm)		d. STREET ADDRESS RD #3 (RumRidge Rd.)	
3. NAME OF DECEASED (Type or print) First Russell Middle William Last Wells		4. DATE OF DEATH Month August Day 22 Year 1966	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 4, 1918
9. AGE (In years last birthday) 48 yrs.		10. IF UNDER 1 YEAR Months 6 Days 18 Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrician		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co., Maryland	
11. BIRTHPLACE (State or foreign country) USA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Vileetus Wells		14. MOTHER'S MAIDEN NAME Florence Parsons	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) Yes War II		16. SOCIAL SECURITY NO. 217-10-2032	
17. INFORMANT Mrs. Nicie Rennie (Sister) RumRidge Road, Salisbury, Maryland		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of Brain 976X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH Instant	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Self-inflicted	
20c. TIME OF INJURY Month, Day, Year 12:30 p.m. 8/22 1966		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Farm		20f. (City or town) (County) (State) Wicomico Co., Maryland	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl E. Royer EXAMINER'S NAME (Type) 409 Camden Avenue, Salisbury, Maryland		22. DATE SIGNED August 22, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Aug. 26, 1966	
23c. NAME OF CEMETERY OR CREMATORY Farlow Cemetery		23d. LOCATION (City or Town) (County) (State) Pittsville Maryland	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR AUG 24 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

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2001 10 13

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner. Give along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Items 14 17 Film G380 9/2/66 mh

12062

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12059

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb 12062 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY New York c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cornwall on the Hudson d. STREET ADDRESS 673 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First HELEN Middle WENCHEL Last WENCHEL		4. DATE OF DEATH Month 8-25-66 Day 19 Year 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-18-04 9. AGE (In years last birthday) 62 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) New York 12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME Casmer Olserky		14. MOTHER'S MAIDEN NAME Balbina Jendrewsky	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. - -	17. INFORMANT Louis Address Mr. Lewis Wencel, New York (husband)
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure 4221 DUE TO (b) Arterio Sclerotic C. V. Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) INTERVAL BETWEEN ONSET AND DEATH hours years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D. EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) 22. DATE SIGNED August 26, 1966	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY St. Thomas Cemetery	23d. LOCATION (City or Town) (County) (State) Cornwall on Hudson, N. Y.
24. FUNERAL DIRECTOR Burbage Funeral Home, Berlin, Md.		25a. REC'D BY REGISTRAR DATE AUG 29 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

15021

15021

White Campbell's Head Volume
Letter Volume C. V. P. 1899

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
12063					12060					
1. PLACE OF DEATH a. COUNTY <i>Wicomico</i>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Pennsylvania</i> b. COUNTY <i>Lancaster</i>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Salisbury</i>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Mt. Joy</i>			d. STREET ADDRESS <i>R.D.# 2</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Peninsula General Hospital</i>					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last <i>MINNIE AMELIA Wenger</i>			4. DATE OF DEATH Month Day Year <i>August 1 1966</i>							
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>May 10/1896</i>		9. AGE (in years last birthday) IF UNDER 1 YEAR IF UNDER 24 HRS. <i>70</i> yrs. <i>2</i> Months <i>21</i> Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House work</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>None</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Lancaster Co., Pa.</i>			12. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		
13. FATHER'S NAME <i>Benjamin Nolt</i>					14. MOTHER'S MAIDEN NAME <i>Amanda Kreider</i>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>No</i>			16. SOCIAL SECURITY NO. <i>162-38-3229</i>		17. INFORMANT Address <i>Mrs. Naomi A. Nolt (Daughter) R.D.#2 Mt Joy, Pa. 17552</i>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Pneumonia - Spasm. negative org.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								INTERVAL BETWEEN ONSET AND DEATH <i>72 hours.</i>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>7/30</i> , 19 <i>66</i> , to <i>8/1</i> , 19 <i>66</i> , that (I) (we) last saw the deceased alive on <i>8/1</i> , 19 <i>66</i> , and that death occurred at <i>8:45</i> M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Joseph C. Fitzgerald</i>					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>8/1/66</i>			
22c. PHYSICIAN'S NAME (Type) <i>Dr. Joseph Fitzgerald</i>					22d. ADDRESS <i>Medical Center Salisbury, Maryland</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>Aug. 4/1966</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Groffdale Cemetery</i>			23d. LOCATION (City, town or county) (State) <i>Lancaster Co., Pa.</i>			
24. FUNERAL DIRECTOR <i>HOLLOWAY & COMPANY</i>					ADDRESS <i>SALISBURY, MARYLAND</i>		25a. REC'D BY REGISTRAR <i>Charles Judge</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



1300

LONG BEACH

R.D. 2

Central Hospital

AMERICA

MINNIE

May 10/1966

X

House work

None

Manchester Co., Pa.

Benjamin Wolf

Amelia Kneiser

Mrs. Naomi A. Wolf (daughter)

R.D. 2, Pa. 17552

100-38-3222

Dr. Joseph Fitzgerald

Burial Aug. 1966 Croftdale Cemetery

Manchester Co., Pa.

HOLLAND & COMPANY SALISBURY, WYOMING

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
20M 1/63

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12064 CERTIFICATE OF DEATH 13441

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital (D.O.A.)			2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 704 E. Church Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ELWOOD First Middle Last WEST			4. DATE OF DEATH Month Day Year August 31 1966		
5. SEX Male			6. COLOR OR RACE White		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH June 25, 1901		
9. AGE (In years last birthday) 65 yrs.			10. IF UNDER 1 YEAR Months Days Hours Min. 2 6		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Horse Groom (Retired)			10b. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (County & State, or foreign country) Sussex Co., Delaware			12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME German West			14. MOTHER'S MAIDEN NAME Martha (unk.)		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. 213-14-6639A		
17. INFORMANT Mrs. Nora W. West (Wife) Address 704 E. Church Street, Salisbury, Maryland					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. Hypertensive C.V. Disease DUE TO (b) years DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH years		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 8-8 , 19 66 , to 8-31 , 19 66 , that (I) (we) last saw the deceased alive on 8-22 , 19 66 , and that death occurred at 12:00 M, from the causes and on the date stated above.					
22a. SIGNATURE Earl L. Royer			22b. DATE SIGNED Aug. 31 / 1966		
22c. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer			22d. ADDRESS Camden Avenue, Salisbury, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify) burial			23b. DATE THEREOF Sept. 3, 1966		
23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery			23d. LOCATION (City, town or county) (State) Salisbury, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND			25a. REC'D BY REGISTRAR DATE SEP 8 1966		
			25b. REGISTRAR'S SIGNATURE Charles Judge		

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Best wishes for
your success

Best wishes

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
12065					12061				
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			c. LENGTH OF STAY IN 1b <u>D.O.A.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>W.</u> Last <u>White</u>			4. DATE OF DEATH Month <u>August</u> Day <u>20</u> Year <u>1966</u>						
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/2/1895</u>		9. AGE (In years last birthday) <u>70</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (County & State, or foreign country) <u>MD. - Wicomico</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <u>Martha E. Barclay</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>142-12-3330</u>		17. INFORMANT <u>Isula White, Nanticoke, MD.</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio sclerosis</u> 4500 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>7/13</u> , 19 <u>66</u> , to <u>8/22</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>7/25</u> , 19 <u>66</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.									
22a. SIGNATURE <u>[Signature]</u>					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/22/66</u>		
22c. PHYSICIAN'S NAME (Type) <u>[Signature]</u>					22d. ADDRESS <u>Hebron MD</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Nanticoke Cem. Nanticoke, MD.</u>		23d. LOCATION (City, town or county) (State) <u>Nanticoke, MD.</u>			
24. FUNERAL DIRECTOR <u>[Signature]</u> ADDRESS <u>Biville, MD.</u>					25a. REC'D BY REGISTRAR <u>[Signature]</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		
					DATE <u>AUG 23 1966</u>				

STATE OF NEW YORK
OFFICE OF THE ATTORNEY GENERAL
ALBANY, N.Y.

IN SENATE
January 15, 1902

REPORT OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
JANUARY 15, 1902

ALBANY: J.B. LEECH, PRINTERS
1902

By order of the Senate,
J.B. LEECH, PRINTERS
1902

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12066

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12062

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b Quantico	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		d. STREET ADDRESS Box # 31	
3. NAME OF DECEASED (Type or print) Thomas Sylvester Williams		4. DATE OF DEATH 8-17-66	
5. SEX M	6. COLOR OR RACE C	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6-24-1920
9. AGE (In years lost birthday) 46 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11b. KIND OF BUSINESS OR INDUSTRY laborer	
11c. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ALONZO WILLIAMS		14. MOTHER'S MAIDEN NAME REBECCA WALLACE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215-16-3226	
17. INFORMANT MARION WILLIAMS		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage DUE TO (b) Laceration of the right brachial artery DUE TO (c) 981X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH Minutes Minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTENSIONAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Stabbed during a domestic quarrel.	
20c. TIME OF INJURY Month, Day, Year Hour, p.m. A.M. 8-17-66		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Quantico Wicomico Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		22. DATE SIGNED 8-17-66	
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.		Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) 8-20-66		23b. DATE THEREOF Wetipquin	
23c. NAME OF CEMETERY OR CREMATORY Wetipquin Wicomico Md		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Hilda L West		25a. REC'D BY REGISTRAR AUG 22 1966	
ADDRESS Salisbury Md		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH														
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND														
CERTIFICATE OF DEATH														
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> d. STREET ADDRESS <u>N. Main St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) <u>William Gilbert Williams</u> First Middle Last					4. DATE OF DEATH <u>August 23</u> 19 <u>66</u> Month Day Year									
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug. 17, 1893</u>		9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS: Hours Min.						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>			11. BIRTHPLACE (County & State, or foreign country) <u>SELBYVILLE DEL.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.M.</u>						
13. FATHER'S NAME <u>D. CASHER WILLIAMS</u>					14. MOTHER'S MAIDEN NAME <u>EFFIE McCABE</u>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) <u>No</u> (If yes give war or dates of service)					16. SOCIAL SECURITY NO. <u>214-32-8625</u>					17. INFORMANT <u>Mrs. W. G. Williams SR. Berlin</u> Address				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> 4200 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____										INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>				
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>8-19</u> , 19 <u>66</u> to <u>8-23</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>8-23</u> , 19 <u>66</u> , and that death occurred at <u>7:30</u> A.M. from the causes and on the date stated above.														
22a. SIGNATURE <u>William R. Ellis</u>					22b. DATE SIGNED <u>8-24-66</u>									
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>8/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u>		23d. LOCATION (City, town or county) (State) <u>BERLIN WOR. MD</u>							
24. FUNERAL DIRECTOR <u>Anna A. Burdette Berlin Md</u>					25a. REC'D BY REGISTRAR <u>gcharles judge</u>					25b. REGISTRAR'S SIGNATURE				

150051



[Faint, mostly illegible text, likely a memorandum or letter. Some words are difficult to discern but appear to include:]

TO: [illegible]
FROM: [illegible]
SUBJECT: [illegible]

[The body of the text consists of several paragraphs of faint, handwritten or typed text that is largely illegible due to fading and low contrast.]

10 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 12068 CERTIFICATE OF DEATH 12064													
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 914 East Church Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
3. NAME OF DECEASED (Type or print) CHARLOTTE BALDWIN WIMBROW			First Middle Last		4. DATE OF DEATH August 6 1966		Month Day Year						
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 10, 1898		9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 0 Days 26 Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Camden, New Jersey			12. CITIZEN OF WHAT COUNTRY?				
13. FATHER'S NAME John G. Figgs					14. MOTHER'S MAIDEN NAME Emma Briddell								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Mr. C. Ercell Wimbrow, 914 E. Church St (Husband)			Address Salisbury, Maryland				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dissecting abdominal aortic aneurysm Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 451X DUE TO (b) Angina DUE TO (c) Myocardial infarction INTERVAL BETWEEN ONSET AND DEATH Days?													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 7:20 , 19 66 , to 8:6 , 19 66 , that (I) (we) last saw the deceased alive on 8:6 , 19 66 , and that death occurred at M , from the causes and on the date stated above.													
22a. SIGNATURE Dr. Henry A. Briele						M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 8.8.66					
22c. PHYSICIAN'S NAME (Type) Dr. Henry A. Briele						22d. ADDRESS Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Aug. 9, 1966		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery			23d. LOCATION (City, town or county) (State) Salisbury, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND						ADDRESS		25a. REC'D BY REGISTRAR Charles Judge					
								25b. REGISTRAR'S SIGNATURE					

12004

Wilmington

Wilmington

Wilmington

Wilmington

Wilmington

CHARLOTTE HALL IN WILMINGTON

Female white

House work

John C. Fries

John C. Fries

Wilmington, N.C.

(Inmate)

Wilmington, N.C.

Dr. Henry A. Fries

Wilmington, N.C.

Wilmington, N.C.

Wilmington, N.C.

HOLLYAY & COMPANY WILMINGTON, N.C.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12069

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12065

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) DOA Peninsula General Hospital				d. STREET ADDRESS 111 Naylor St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First NORRIS Middle EMORY Last WOOTERS				4. DATE OF DEATH Month August Day 1 Year 19 66			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-27-28		9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DRYWALL INSTALLER CONSTRUCTION		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) DELAWARE		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME FRANK BENJAMIN WOOTERS				14. MOTHER'S MAIDEN NAME GRACE ELIZABETH KNOWLES WOOTERS			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES KOREAN		16. SOCIAL SECURITY NO. 221-16-1208		17. INFORMANT GRACE E. WOOTERS - SALSBURY MARYLAND			Address
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4201 IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) DUE TO (c) DUE TO						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) 409 Camden Ave. Salisbury, Md.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL AUG 4 1966 BLADES CEMETERY		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY BLADES DELAWARE		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR Watson Funeral Home, Seaford, Del.				25a. REC'D BY REGISTRAR AUG 4 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12070
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH
12066

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				d. STREET ADDRESS <u>R.D. #5, Zion Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ira</u>		First <u>Watson</u>		Last <u>Wright, Jr.</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> Year <u>1966</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 14, 1919</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>4</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration service & repair</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Ira W. Wright, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Phillips</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>War II</u>		17. INFORMANT <u>Mrs. Mary F. Wright (wife), R.D. #5, Zion Rd. Salisbury, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>yes</u> <u>yes</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>N/A</u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 18</u> , 19 <u>66</u> to <u>Aug 18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Aug 18</u> , 19 <u>66</u> , and that death occurred at <u>8:57</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Dr. John T. Bulkeley</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/19/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. John T. Bulkeley</u>				22d. ADDRESS <u>Salisbury, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>August 22, 66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY, SALISBURY, MARYLAND</u>				25a. REC'D BY REGISTRAR <u>AUG 22 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12071

CERTIFICATE OF DEATH

12067

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Worcester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Berlin	
c. LENGTH OF STAY IN lb 9 days		d. STREET ADDRESS Rt. 1, Box 257 A	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital, Salisbury, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Mary (none) Yamrick		4. DATE OF DEATH Month Day Year 8 18 19 66	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 22, 1892
9. AGE (In years last birthday) yrs. 73		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home		10b. KIND OF BUSINESS OR INDUSTRY at home	
11. BIRTHPLACE (County & State, or foreign country) Czechoslovakia		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Gregorwicz		14. MOTHER'S MAIDEN NAME Thersa Gabor	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no		16. SOCIAL SECURITY NO.	
17. INFORMANT Mr. Charles Gregor		Route 1 Berlin, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro- Vascular Accident DUE TO 443X (b) Bronchopneumonia DUE TO (c) Arteriosclerotic cardio-vascular disease with hypertension.			INTERVAL BETWEEN ONSET AND DEATH 2 mo. 3 days Years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 8/9 , 19 66 , to 8/18 , 19 66 , that (I) (we) last saw the deceased alive on 8/18 , 19 66 , and that death occurred at 8:40 P.M. , from causes and on the date stated above.			
22a. SIGNATURE Andrew C Mitchell M.D.		22b. DATE SIGNED 8/19/66	
22c. PHYSICIAN'S NAME (Type) A. C. Mitchell, M. D.		22d. ADDRESS Deer's Head State Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 8-21, 1966	23c. NAME OF CEMETERY OR CREMATORY Mt. Olive Cemetery	23d. LOCATION (City or Town) (County) (State) Sandtown, Kent Co., Del.
24. FUNERAL DIRECTOR Thomas F. Wallace ADDRESS Salisbury, Md.		25a. REC'D BY REGISTRAR DATE AUG 22 1966	25b. REGISTRAR'S SIGNATURE Charles Judge

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